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# People's Republic of China: Social Work Services Policy and Delivery Modes for the Elderly with Special Difficulties

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Asian Development Bank

## CURRENCY EQUIVALENTS

(as of 31 December 2016)

| | | |
|---|---|---|
| Currency Unit | – | Yuan (CNY) |
| CNY1.00 | = | $0.1439 |
| $1.00 | = | CNY 6.9502 |

## ABBREVIATIONS

| | | |
|---|---|---|
| ADB | – | Asian Development Bank |
| ADL | – | activities of daily living |
| ESD | – | elderly with special difficulties |
| IADL | – | instrumental activities of daily living |
| GDS | – | Geriatric Depression Scale |
| MOCA | – | Ministry of Civil Affairs |
| PRC | – | People's Republic of China |
| SWOE | – | social work service organizations for the elderly |

## GLOSSARY

| | | |
|---|---|---|
| ADL | – | The basic self-care activities necessary for daily life |
| comorbidity | – | Presence of two or more chronic diseases at the same time. |
| ESD | – | Elderly experiencing special (severe) physical, psychological, and/or financial difficulties. |
| IADL | – | Activities that facilitate independent living and are more complex than ADL |
| LSNS-6 | – | A six item abbreviated version of the Lubben Social Network Scale |
| Oldest old | – | Individuals 80 years of age and over |

## NOTE

In this report, "$" refers to US dollars unless otherwise stated.

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# PREFACE

1. The elderly with special difficulties (ESD) are those with special (severe) physical, psychological, and/or financial difficulties. Moreover, these needs are becoming more diverse and individualized, requiring a combination of targeted poverty-reduction measures and affordable medical and social services.

2. The government of the People's Republic of China (PRC) has increasingly recognized that social work can play a coordinating role in the development and provision of elderly care services, including for ESD. Social workers can practice in a variety of settings along the continuum of aging, wellness, and long-term care. Social workers in these settings could also fulfill a unique role as the primary focus of social work is the psychosocial well-being of the elderly and their families.

3. The following report has been prepared as one of five reports in a technical assistance project on Social Work Services Policy and Delivery Modes for the Elderly with Special Difficulties. This report particularly focuses on developing an implementation framework, guidelines, a monitoring and evaluation system, and government procurement mechanisms for social work services for the elderly with special difficulties. This entails:

(i) assessing gendered needs of the ESD and corresponding social services,
(ii) identifying good practices in ESD social work service delivery modes,
(iii) developing guidelines for ESD social work services, and
(iv) outlining a broad implementation framework for these social service guidelines.

# I. GENDERED NEEDS OF THE ELDERLY WITH SPECIAL DIFFICULTIES AND CORRESPONDING SOCIAL SERVICES

## A. Introduction

### 1. Research Background

#### a. Heterogeneity of the Elderly Population

1. Heterogeneity in the elderly population is a recognized and important condition.[1] Individuals traditionally classified as "elderly" fall within an age span of 40 years or more. Moreover, there is marked variation and diversity among individuals within specific age groups.

2. In order to provide effective elderly care, older people should not be treated as though they constitute a uniform group.[2] The elderly actually includes those who are often called the "young old" and others who are often termed the "oldest old". It also includes those from backgrounds of privilege, poverty, or low income; those with children or who live alone or in empty-nest households; and those who are healthy and those who are frail. In addition, the aging experience of older women differs from that of older men. Gender also affects the extent to which different individuals can access resources, including money and good nutrition. This bundle of diversities means that elderly care should be specific, since the effectiveness of different forms of elderly care will depend on which group of older persons is being targeted.

#### b. The Elderly with Special Difficulties: An Elderly Group Requiring Special Concern

3. The People's Republic of China (PRC) has a significant population of elderly with special difficulties (ESD), including those unable to perform daily activities and those experiencing poverty or low income. Moreover, rapid aging of the population means that the number of PRC elderly with chronic diseases or unable to perform daily activities will continue to grow. This projected rapid increase in the elderly and the impact of attendant chronic illness and disability, present a great challenge for PRC social and medical services.

4. ESD are the greatest users of social and medical services and so effective services can improve their quality of life. However, the current PRC elderly care system is not responding effectively to their needs and demands. Effectively satisfying the needs of these ESD is thus the touchstone of PRC elderly social service reform.

### 2. Research Objectives

5. This report assesses the needs of ESD and identifies relevant social work services to address their needs. Specifically, the study focuses on

(i) basic characteristics of the PRC elderly population,
(ii) prevalence rates and characteristics of ESD,
(iii) health and functional status of ESD,
(iv) ESD care needs, and
(v) relevant social work services to address ESD needs.

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[1] National Institute on Aging. 1987. *Personnel for health needs of the elderly through year 2020*. pp. 23–24.

[2] WHO Regional Office for the Western Pacific. 2003. *Aging and Health: A Health Promotion Approach for Developing Countries*. p. 7

## B. Research Methods

6. The methods used in this report include a literature review that draws on international and PRC materials, an analysis of PRC secondary data, and fieldwork conducted in the PRC.

### 1. Literature Review

7. A literature review guided development of an operational definition for ESD in the PRC and identification of relevant social work services to address those needs. Findings from the literature review were also helpful in supplementing secondary data analysis. This literature review included reports, research papers, and articles addressing the health, care needs, and social work services for older people.

### 2. Secondary Data Analysis

8. Secondary data analysis was mainly used to analyze basic characteristics of the elderly population, the proportion and features of ESD, and to assess ESD health and care needs.

#### a. Data Sources

9. Data used in this report was mainly drawn from the 2010 Sampling Survey of the Aged Population in the Rural/Urban PRC. This multistage stratified sample was chosen from 20 provinces, autonomous regions and municipalities. The final sample included 2,000 villages and urban communities (residential committees) in 160 counties and urban districts. The 2010 survey interviewed 19,986 elderly persons aged 60 years or older, of which 10,032 were urban elderly and 9,954 rural elderly.[3.]

#### b. Variables and Measurements

10. Variables used in this report include the sociodemographic context, functional status, and health of the elderly (Table 1).

**Table 1: Description of Variables Used in This Report**

| Domains | Variables |
|---|---|
| Sociodemographic context | Age, sex, location of residence (urban or rural), marital status, educational attainment, self-rated economic status, living arrangements, and number of children alive |
| Health and functional status | ▪ Self-rated health<br>▪ Physical health: chronic diseases and comorbidity conditions<br>▪ Functional status: activities of daily living (ADL), instrumental activities of daily living (IADL), sensory functions (hearing and vision impairment), and incontinence<br>▪ Mental health: depression (GDS-15)<br>▪ Social health: social network (LSNS-6) |

[3] Wu, Y.S. and Guo, P. (Chief editor). 2010. *Data Analysis of the Sampling Survey of the Aged Population in Urban/Rural China*. Beijing: China Society Press.

### i. Sociodemographic Context

11. Variables for sociodemographic characteristics included age, sex, residence (urban or rural), marital status, educational attainment, self-rated economic status, living arrangements, and number of children alive.

12. **Self-rated economic status.** Self-rated economic status was measured with a single question formulated as: “How would you rate your economic condition?” with the possible choices being (1) more than adequate, (2) adequate, (3) just adequate, (4) not adequate, or (5) severely inadequate. In this report, ESD are defined as those who perceived their economic status to be “not adequate” or “severely inadequate”.

13. **Living arrangements.** Living arrangements were classified into four categories: living alone, living with only a spouse, living with one’s children and others, or living only with others. Here, “children” included son(s), daughter(s), son-in-law(s) and daughter-in-law(s), but excluded grandchildren.

### ii. Health and Functional Status

14. Items on health and functional status included self-rated health; physical health, including the presence of chronic diseases and comorbid conditions; functional status, including activities of daily living, instrumental activities of daily living, sensory functions (hearing impairment and vision impairment) and incontinence; and mental and social health, including depression and social network status (social isolation).

15. **Self-rated health.** Self-rated health was measured by a single question formulated as: *How would you rate your health at present?* with possible choices of (1) very good, (2) good, (3) fair, (4) bad, or (5) very bad. Although the answer to the self-rated health question was subjective, it has provided a statistically powerful predictor of mortality across populations,[4] indicating the validity of this measurement.

16. **Presence of chronic diseases and comorbid conditions.** All elderly respondents were asked if they were experiencing each of the chronic diseases listed in the questionnaire at the time of interview. Fifteen categories of chronic disease were selected for the study, namely: hypertension, heart diseases, cerebrovascular diseases, diabetes mellitus, cancer or tumor, dementia, Parkinson's disease, chronic bronchitis, kidney diseases, liver diseases, diseases of urinary system, arthritis, osteoporosis, cervical/lumbar spondylosis and glaucoma/cataract.

17. Comorbidity refers to the presence of two or more chronic diseases at the same time. The impact of comorbidity on the functioning and quality of life for the elderly may be significantly greater than the sum of individual effects from these diseases.[5] Predictably, comorbidity is often associated with higher rates of health care utilization and higher costs.

18. **ADL and ADL disability*.*** Activities of daily living (ADLs) are the basic self-care activities necessary for daily life. ADLs are used in many settings as indicators of eligibility for care

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[4] Idler, Ellen L; Benyamini, Yael. 1997. Self-rated health and mortality: a review of twenty-seven community studies. *Journal of Health and Social Behavior*. 38(1): 21–37.

[5] Marengoni A., Angleman S., Melis R., et al. 2011. Aging with multimorbidity: a systematic review of the literature. *Ageing Resources Review,* 10(4): 430–9.

services, particularly long term care services, and they are likely to reflect a significant need for care.[6]

19. ADLs are measured by six self-reported activities of daily living: eating, dressing, toiletry, getting in and out of bed, bathing, and walking indoors. Most of these ADL items are included in classic ADL scales.[7,8] For each item, elderly respondents were asked to choose one of the following alternatives to describe their ability to perform it alone: without difficulty, with some difficulty, or unable to do. In this report, ADL disability is defined as at least one ADL item performed with some difficulty or unable to do, and severe ADL disability as at least one ADL item unable to be performed.

20. **IADL and IADL disability.** Instrumental activities of daily living (IADLs) refer to activities that facilitate independent living and are more complex than ADLs. IADL are measured by six daily activities in this report, including cooking, shopping, laundry, transportation, managing finances, and using the telephone. Elderly respondents were asked to assess their ability to perform each of these activities alone by choosing one of the following alternatives: without difficulty, with some difficulty, or unable to perform. In this report, IADL disability is defined as at least one IADL item performed with some difficulty or unable to be performed, and severe IADL disability as inability to perform at least one IADL item.

21. **Hearing and vision impairments.** Aging is frequently associated with a decline in both vision and hearing. Hearing or vision impairment was measured by a single question formulated as: "Can you hear or (see things) clearly?" with the possible choices being (1) very clearly, (2) fairly clearly, (3) so-so, (4) not clearly, and (5) almost or entirely unclear. The last two responses were combined as constituting hearing or vision impairment.

22. **Incontinence.** Incontinence is one of the most common impairments of older age and a strong predictor of the need for care. Elderly respondents were asked if they had experienced incontinence (including bladder continence and bowel continence) during the past year and the frequency of incontinence. This report used a frequency of incontinent episodes exceeding twice monthly as defining the elderly with incontinence.

23. **Depression.** Depression was assessed using a short form of the GDS (Geriatric Depression Scale). The short form of the GDS consists of 15 items that ascertain how an elderly respondent felt or behaved during the past week. The resulting GDS score is a sum of 15 items and it ranges in value from 0 to 15. A high score denotes greater psychological distress. A score of 8 or higher is used to classify individuals as experiencing depression. The GDS is one of the most widely used such measures and yields reliable results with high a validity for assessing depression.[9] [10]

24. **Social network and social isolation.** An individual's social network is measured using the LSNS-6, a six-item abbreviated version of the Lubben Social Network Scale. The LSNS-6

[6] WHO. 2015. *World report on ageing and health.* World Health Organization. p. 69.

[7] Katz, S., Ford, A.B., Moskowitz, R.W., et al. 1983. Studies of illness in the aged. The index of ADL: a standardized measure of biological and psychosocial function. *Journal of the American Medical Association*. 185: 914–919.

[8] Mahoney, F.I., Barthel, D.W. 1965. Functional evaluation: The Barthel Index. *Maryland State Medical. Journal.*14:61–65.

[9] Barbara Berkman. (Editor). 2006. *Handbook of Social Work in Health and Aging*. Oxford: Oxford University Press, p.154.

[10] Yesavage, A., Brink, T. L., Rose, T.L., et al. 1982. Development and validation of a geriatric depression screening scale: A preliminary report. *Journal of Psychiatric Research.* pp. 17:37–49.

assesses two critical domains of social networks; the family and friends and neighbors. It is a valid and reliable measure of social health and is used globally as a screening tool for social isolation in elderly individuals. The total scale score is an equally weighted sum of the six items, with scores ranging from 0 to 30. A score of less than 12 is used to identify older persons as being socially isolated.[11]

#### c. 2.2.3 Reliability of the Measures

25. Table 2 presents reliability coefficients for the ADL, IADL, LSNS-6 and GDS-15 scales. It uses Cronbach's α to measure reliability. An acceptable range of coefficient alpha values is from 0.70 to 0.90.[12,13] The coefficients in Table 2 indicate good reliability for these four measures.

**Table 2: Reliability Coefficients**

| Variable Category | Number of Items | Reliability coefficients |
|---|---|---|
| ADL | 6 | 0.899 |
| IADL | 6 | 0.899 |
| LSNS-6 | 6 | 0.848 |
| GDS-15 | 15 | 0.798 |

#### d. Weighting Method

26. Survey results were weighted to obtain estimates for the overall elderly population in 2010. The weighting method is described in the report *Data Analysis of the Sampling Survey of the Aged Population in Urban/Rural the PRC 2010.*[14]

### 3. Fieldwork

27. Fieldwork for this report aimed to identify social work services to meet the needs of ESD. Fieldwork methods used primarily in Xining, Qinghai Province included interviews with key informants and focus group discussions. Fieldwork respondents were drawn from administrators in local civil affairs departments and relevant personnel in social work service agencies. In addition, participants attending a November 2016 training workshop on Social Work Services Policy and Delivery Modes for ESD in Beijing were asked their opinions on ESD needs and related social work services. Workshop participants were social work service agency administrators from Beijing Municipality, Fujian, Guangdong, Hebei, Hainan, Jiangsu and Zhejiang provinces in the developed eastern region of the PRC; Henan, Hubei, and Anhui provinces from the poorer central PRC; Qinghai, Gansu, and Inner Mongolia from the poorer northwest; Guangxi, Sichuan, and Chongqing from the poorer southwest; and Heilongjiang and Jilin from the northeastern rustbelt region.

## C. Sociodemographic Characteristics of the PRC Elderly

28. This section examines basic characteristics of the PRC elderly population, including their ages, sex, marital status, educational attainment, economic status, living arrangements, and

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[11] Lubben J., Blozik E., and Gillmann G., et al. 2006. Performance of an abbreviated version of the Lubben Social Network Scale among three European community-dwelling older adult populations. *Gerontologist.* 46 (4): 503–513.
[12] DeVellis, R.F. Scale development. 1991. *Theory and applications.* Newbury Park, CA: Sage.
[13] Nunnally, J.C. 1978. *Psychometric theory* (2nd ed.). New York: McGraw-Hill.
[14] Wu, Y.S. and Guo, P. (Chief editor). 2010. *Data Analysis of the Sampling Survey of the Aged Population in Urban/Rural China*. Beijing: China Society Press.

number of children alive. These demographic and socioeconomic factors are important determinants of degree of vulnerability among the elderly.

### 1. Age and Sex

29. Aggregate data from the 2010 PRC census reveals that there were 177.59 million people aged 60 years and over in the PRC. More than half (56.2%) of the elderly in 2010 were aged 60–69 years old (Table 3), about one-third (32.0%) were aged 70–79, and 11.8% were aged 80 years and over. Over the next few decades, the older population will continue to change its internal age structure. This trend will have a direct effect on provision of elderly care.

**Table 3: Population Aged 60 and Over, by Age and Place of Residence, 2010**

| Age Groups | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| 60-64 | 26.04 | 33.3 | 32.63 | 32.9 | 58.67 | 33.0 |
| 65-69 | 17.91 | 22.9 | 23.20 | 23.4 | 41.11 | 23.2 |
| 70-74 | 14.78 | 18.9 | 18.20 | 18.3 | 32.97 | 18.6 |
| 75-79 | 10.53 | 13.5 | 13.32 | 13.4 | 23.85 | 13.4 |
| 80-84 | 5.97 | 7.6 | 7.49 | 7.5 | 13.46 | 7.6 |
| 85+ | 3.07 | 3.9 | 4.47 | 4.5 | 7.53 | 4.2 |
| Total | 78.29 | 100.0 | 99.30 | 100.0 | 177.59 | 100.0 |

* In millions.

**Table 4: Population Aged 60 and Over, by Age, Sex, and Place of Residence, 2010**

| Age and Sex | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| <80 | | | | | | |
| Male | 34.23 | 49.4 | 44.04 | 50.4 | 78.27 | 50.0 |
| Female | 35.03 | 50.6 | 43.31 | 49.6 | 78.34 | 50.0 |
| Total | 69.26 | 100.0 | 87.35 | 100.0 | 156.61 | 100.0 |
| ≥80 | | | | | | |
| Male | 3.96 | 43.8 | 4.82 | 40.3 | 8.77 | 41.8 |
| Female | 5.08 | 56.2 | 7.14 | 59.7 | 12.21 | 58.2 |
| Total | 9.04 | 100.0 | 11.95 | 100.0 | 20.99 | 100.0 |
| Total | | | | | | |
| Male | 38.18 | 48.8 | 48.86 | 49.2 | 87.04 | 49.0 |
| Female | 40.11 | 51.2 | 50.45 | 50.8 | 90.55 | 51.0 |
| Total | 78.29 | 100.0 | 99.30 | 100.0 | 177.59 | 100.0 |

* In millions.

30. As in most parts of the world, women in the PRC live longer than men, with a PRC life expectancy of 72.9 years for men and 79.0 years for women in 2010.[15] In 2010, there were 87.04 million elderly men and 90.55 million elder women. The proportion of men and women aged 60–79 was basically equal at 50% in 2010. However, the proportion of women increased with age and women made up a greater proportion of the PRC's oldest old (aged 80 and over) in 2010 (58%). The proportion of women in the 60–64 years, 65–69 years, 70–74 years, 75–79

[15] Wang H, Dwyer-Lindgren L, Lofgren KT, et al. 2012. Age-specific and sex-specific mortality in 187 countries, 1970–2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*. 80: 2071–94.

years, 80–84 years and the 85 years and over age groups were 49.2%, 49.5%, 50.3%, 52.7%, 57.5% and 59.4% respectively in 2010.

### 2. Marital Status

31. Table 5 indicates the marital status of the PRC elderly by rural or urban residence in 2010. The majority (about 80%) of older people were married, but almost 20% were widowed. Less than 2% were divorced or had never married. The proportion of those widowed increased with age, being 14.6% for those aged 60–79 years and 55.8% for those aged 85 years and over (Table 6).

**Table 5: Marital Status by Place of Residence, 2010**

| Marital Status | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No. * | % | No. | % | No. | % |
| Married | 64.58 | 82.5 | 75.89 | 76.4 | 140.47 | 79.1 |
| Widowed | 12.88 | 16.5 | 21.71 | 21.9 | 34.59 | 19.5 |
| Divorced | 0.55 | 0.7 | 0.38 | 0.4 | 0.93 | 0.5 |
| Never married | 0.28 | 0.4 | 1.32 | 1.3 | 1.60 | 0.9 |
| **Total** | **78.29** | **100.0** | **99.30** | **100.0** | **177.59** | **100.0** |

* In millions.

32. The marital status of men differed significantly from that of women. Older women were less likely to be married than their male counterparts, and more likely to be widowed (28.7% compared with 9.9%). This was more evident for people aged 80 years and over with 72.0% of women aged 80 years and over being widowers in 2010 (8.80 million people) compared with 33.2% of men. There was also a marked urban-rural difference in the marital status of older people, and particularly for the oldest old. Most rural elderly aged 80 years and over were widowed in 2010 (61.3%) compared with 48.5% of those in urban areas.

**Table 6: Proportion of Older Persons Widowed, by Age, Sex, and Place of Residence, 2010**

| Age and Sex | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| <80 | | | | | | |
| Male | 1.59 | 4.6 | 4.09 | 9.3 | 5.67 | 7.2 |
| Female | 6.92 | 19.7 | 10.29 | 23.8 | 17.21 | 22.0 |
| Total | 8.51 | 12.3 | 14.38 | 16.5 | 22.88 | 14.6 |
| ≥80 | | | | | | |
| Male | 0.98 | 24.6 | 1.93 | 40.2 | 2.91 | 33.2 |
| Female | 3.40 | 67.0 | 5.40 | 75.6 | 8.80 | 72.0 |
| Total | 4.38 | 48.5 | 7.33 | 61.3 | 11.71 | 55.8 |
| Total | | | | | | |
| Male | 2.56 | 6.7 | 6.02 | 12.3 | 8.58 | 9.9 |
| Female | 10.32 | 25.7 | 15.69 | 31.1 | 26.01 | 28.7 |
| **Total** | **12.88** | **16.5** | **21.71** | **21.9** | **34.59** | **19.5** |

* In millions.

### 3. Educational Level

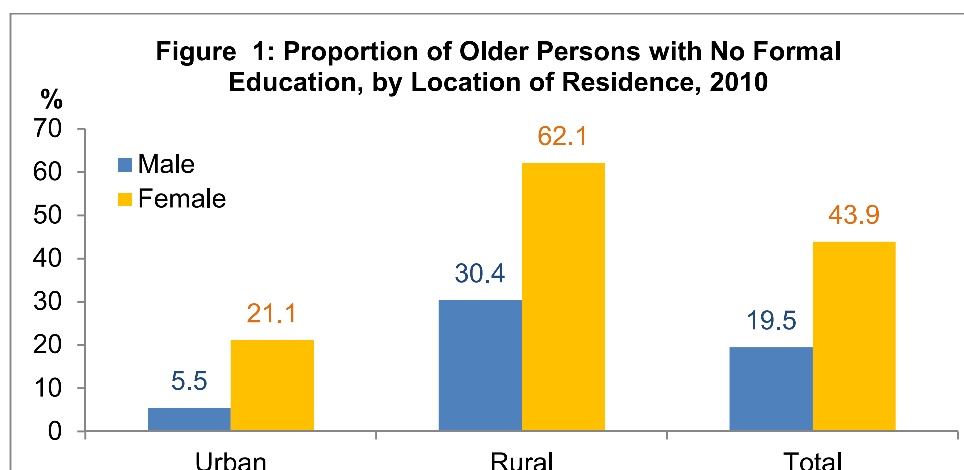
33. Table 7 indicates the educational attainment of the PRC elderly by place of residence in 2010. The education level of older people was very low. About one-third (31.9%) of older people lacked any formal education, 38.5% had completed primary school, and only 11.2% senior high school or above. The educational attainment of older people was also much lower in rural areas. Nearly half (46.5%) of the rural elderly lacked any formal education and less than 2% had completed senior high school or above.

**Table 7: Education Level, by Place of Residence, 2010**

| Education Level | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| No formal education | 10.60 | 13.5 | 46.14 | 46.5 | 56.74 | 31.9 |
| Primary school | 26.52 | 33.9 | 41.94 | 42.3 | 68.46 | 38.5 |
| Junior high school | 23.02 | 29.4 | 9.52 | 9.6 | 32.54 | 18.3 |
| Senior high school or more | 18.20 | 23.2 | 1.65 | 1.7 | 19.85 | 11.2 |
| Total | 78.35 | 100.0 | 99.25 | 100.0 | 177.59 | 100.0 |

* In millions.

34. There were huge differences in the educational attainment of elderly men and women in both urban and rural areas. The proportion of elderly lacking any formal education was much higher for women (21.1% in urban areas and 62.1% in rural areas) than men (5.5% in urban areas and 30.4% in rural areas).




### 4. Economic Status

35. Economic status is one of most important factors affecting the general health and wellbeing of older people. However, about one-third of elderly respondents self-assessed their economic situation as insufficient or severely short of money, with 55% barely able to make ends meet. Only 12% considered they had enough funds and 1.3% more than enough (Table 8). The rural elderly rated their economic situation as worse than did the urban elderly. Only 8.8% of rural elderly rated their economic situation as adequate or more than adequate compared with 18.9% for the urban elderly.

**Table 8: Self-rated Economic Status, by Place of Residence, 2010**

| Self-rated Economic Status | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| More than enough | 1.19 | 1.5 | 1.08 | 1.1 | 2.26 | 1.3 |
| Enough | 13.64 | 17.4 | 7.65 | 7.7 | 21.29 | 12.0 |
| Just enough | 47.21 | 60.3 | 51.41 | 51.8 | 98.62 | 55.5 |
| Not enough | 13.31 | 17.0 | 30.85 | 31.1 | 44.16 | 24.9 |
| Severely short | 2.94 | 3.8 | 8.31 | 8.4 | 11.25 | 6.3 |
| **Total** | **78.29** | **100.0** | **99.30** | **100.0** | **177.59** | **100.0** |

* In millions.

### 5. Living Arrangements

36. Living arrangements can affect the elderly's perception of vulnerability or safety at home. In 2010, about 40% of all older people lived with spouse only and about 10% lived alone. From this, it is apparent that close to half of the elderly lived in "empty-nest" households (Table 9). Another 50% lived with children (38.9%) or with others (11.8%).

37. There was a significant urban-rural difference in living arrangements. Both the proportion of older people living with children and the proportion of those living alone were significantly higher in rural than urban areas (10.6% vs 8.6% and 41.8% vs 35.1%). In contrast, the proportion of older people living with only a spouse was lower in rural than urban areas (35.0% vs 45.4%).

**Table 9: Living Arrangements, by Place of Residence, 2010**

| Living Arrangements | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| Living alone | 6.73 | 8.6 | 10.53 | 10.6 | 17.26 | 9.7 |
| Living with spouse only | 35.54 | 45.4 | 34.74 | 35.0 | 70.28 | 39.6 |
| Living with children | 27.49 | 35.1 | 41.53 | 41.8 | 69.02 | 38.9 |
| Living with others | 8.53 | 10.9 | 12.51 | 12.6 | 21.04 | 11.8 |
| **Total** | **78.29** | **100.0** | **99.30** | **100.0** | **177.59** | **100.0** |

* In millions.

### 6. Number of Children Alive

38. Children and other family members play a key role in providing financial and psychological support to the elderly. In 2010, the PRC elderly had an average of 3.2 living children (2.7 for the elderly in urban areas and 3.6 for the rural elderly). About 98% of elderly had at least one child, and 62.8% had three or more children. About 3.4 million elderly (2%) did not have any living children.

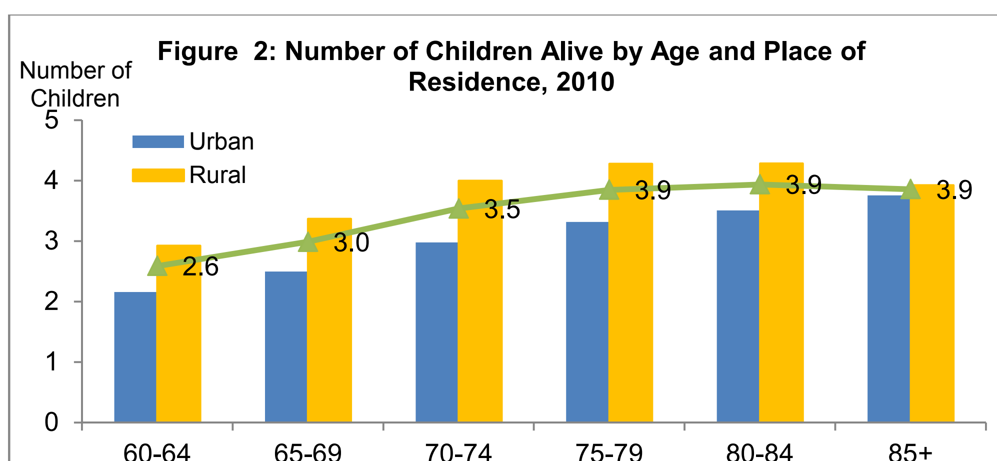
39. The average number of children decreased significantly among younger age cohorts. The elderly aged 70 years and older had an average of 3.5 or more children and those aged 60-69 years had three or less children (Figure 2). Even fewer children were found in the age group

45–49 years (having less than two children).[16] This indicates that future elderly will have fewer children to support them and the proportion of the elderly without any child is likely to increase.

**Table 10: Number of Children Alive, by Place of Residence, 2010**

| No. of Children | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| 0 | 1.11 | 1.4 | 2.29 | 2.3 | 3.41 | 1.9 |
| 1 | 11.46 | 14.6 | 5.64 | 5.7 | 17.10 | 9.6 |
| 2 | 27.51 | 35.1 | 17.97 | 18.1 | 45.48 | 25.6 |
| 3 | 18.66 | 23.8 | 25.06 | 25.2 | 43.72 | 24.6 |
| ≥4 | 19.56 | 25.0 | 48.33 | 48.7 | 67.89 | 38.2 |
| **Total** | **78.29** | **100.0** | **99.30** | **100.0** | **177.59** | **100.0** |

* In millions




## D. Prevalence and Characteristics of the Elderly with Special Difficulties

40. The literature review, and an associated study report on the international experience on social work services for ESD,[17] indicated that the most vulnerable or ESD groups are the oldest old, those with severe financial difficulties, those living alone, without living children, or with functional limitations to their activities of daily living (ADL disability). The following section addresses the prevalence and characteristics of these five types of ESD.

### 1. The Oldest Old

41. Based on the 2010 Census, there were about 20.99 million oldest old (aged 80 years and over) in 2010, accounting for 11.8% of all elderly (Table 11). The oldest old comprised 10.1% of all older men and 13.5% of all older women. Aging of the baby boomers will make the oldest

[16] CHARLS Research Team, Peking University. 2013. *Challenges of Population Aging in China: Evidence from the National Baseline Survey of China Health and Retirement Longitudinal Study.* May.

[17] Peter Chan. 2016. TA 8903 Social Work Services Policy and Delivery Modes for the Elderly with Special Difficulties. Study Report on the International Experience on Social work Services for the Elderly with Special Difficulties. 2016. Unpublished.

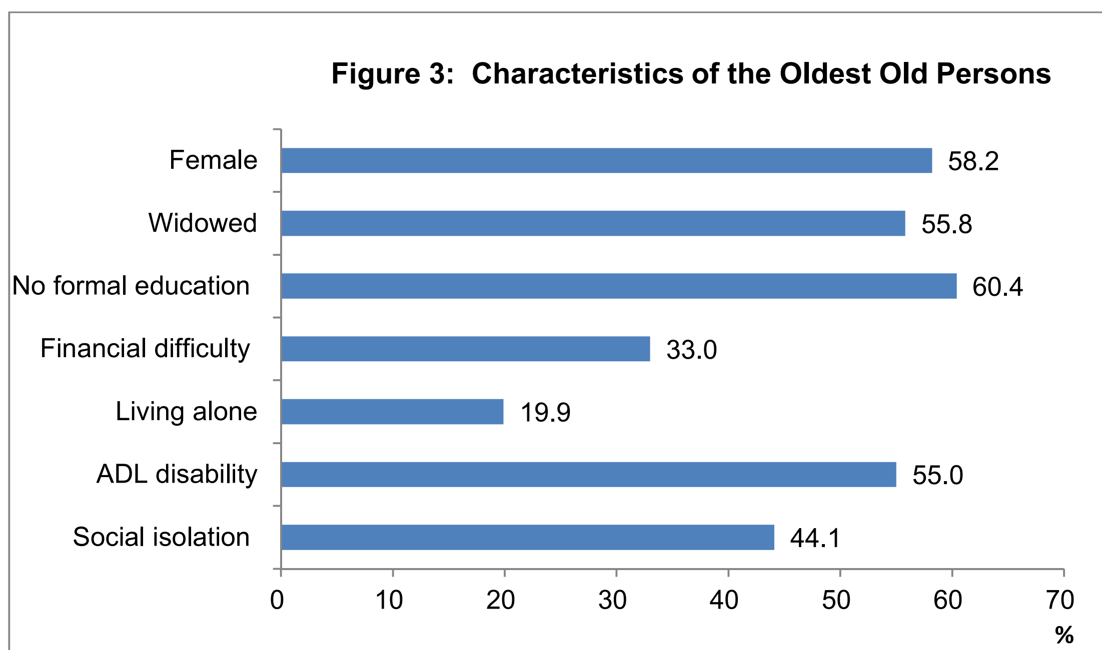
old the fastest-growing age group in the PRC. There will be 90.43 million people aged 80 years and over by 2050 or 20% of all older people in 2050.[18]

**Table 11: The Oldest Old, by Sex and Place of Residence, 2010**

| Sex | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| Male | 3.96 | 10.4 | 4.82 | 9.9 | 8.77 | 10.1 |
| Female | 5.08 | 12.7 | 7.14 | 14.2 | 12.21 | 13.5 |
| **Total** | **9.04** | **11.5** | **11.95** | **12.0** | **20.99** | **11.8** |

* In millions.

42. The oldest old differed markedly from other elderly groups in many aspects. Firstly, most elderly below the age of 80 were relatively healthy, but the oldest old generally required assistance. More than half (55%) of the oldest old had limitations in one or more ADL's in 2010. Secondly, they were predominantly widows, with very low levels of education and frequently living in social isolation. In 2010, 55.8% of the oldest old were widowed, about 60% had no formal education, and 44% were at risk for social isolation. Thirdly, the proportion of the oldest old living alone was considerably higher than that for elderly aged below 80. About 20% of the elderly 80 years and older over lived alone in 2010 compared with 8.4% of the elderly aged 60–79 years.




### 2. The Elderly in Severe Financial Difficulty

43. Despite the advent of social pension programs that have helped reduce the extent of poverty among the elderly, impoverishment or special financial difficulties of the elderly remain a significant problem. The elderly with special financial difficulties can be subjectively defined as those who perceived their economic status to be inadequate or severely inadequate. This group

[18] Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat. 2013. *World Population Prospects: The 2012 Revision.* New York.

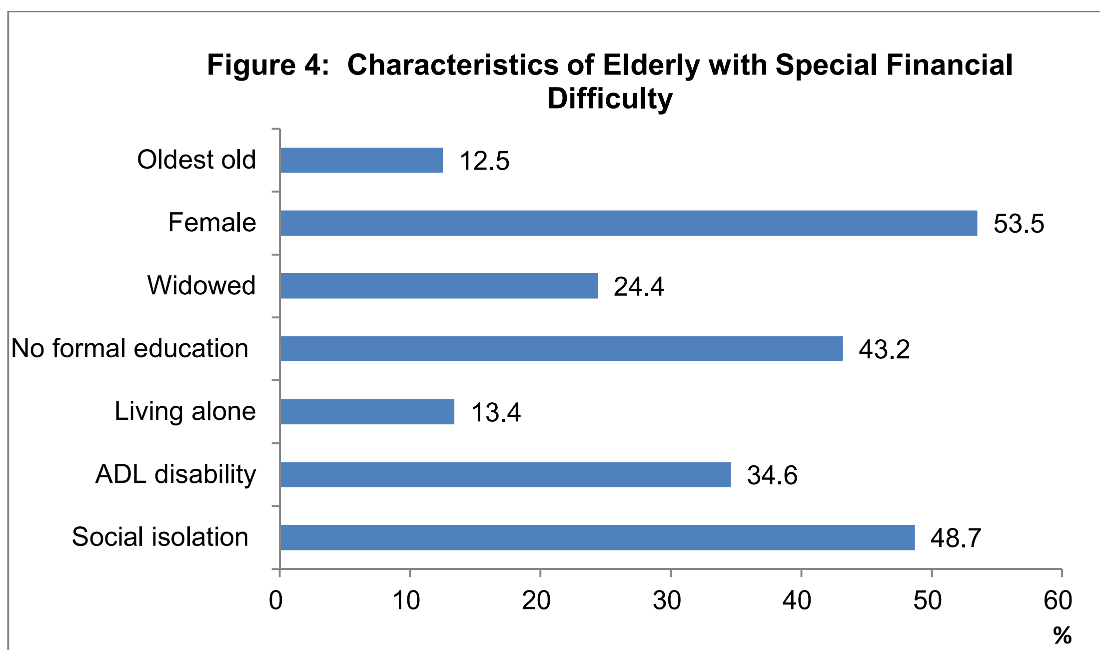
constituted about 55 million people, or 31.2% of all older people living with severe financial difficulty, in 2010 (Table 12). The proportion of elderly in rural areas with special financial difficulties was nearly twice that for urban areas (39.4% vs 20.8%). In addition, older women in urban areas were more likely to experience special financial difficulties than older men (24.6% vs 16.8%).

**Table 12: Elderly with Severe Financial Difficulty, by Sex and Place of Residence, 2010**

| Sex | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| Male | 6.40 | 16.8 | 19.40 | 39.7 | 25.80 | 29.6 |
| Female | 9.85 | 24.6 | 19.76 | 39.2 | 29.61 | 32.7 |
| **Total** | **16.26** | **20.8** | **39.16** | **39.4** | **55.42** | **31.2** |

* In millions.

44. The elderly living with special financial difficulties exhibited several features of particular concern: a higher prevalence of ADL disability, a lower level of formal education, and a greater risk of social isolation. In 2010, about one-third of ESD with severe financial difficulties had a limitation in one or more activities of daily living, 43.2% had no formal education, and close to half (48.7%) were at risk of social isolation.




### 3. The Elderly Living Alone

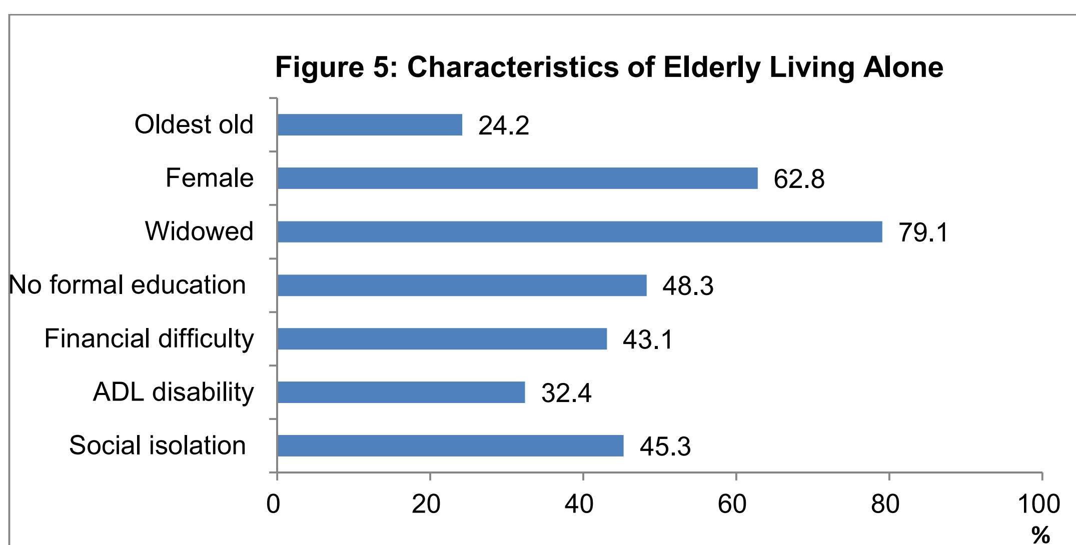
45. **The elderly living alone were one of most vulnerable groups surveyed**. In 2010, about 17 million, or 9.7% of all elderly lived alone (Table 13). The proportion of elderly living alone was higher in rural than urban areas (10.6% vs 8.6%), and considerably higher for older women than older men (12.0% vs 7.4%). The proportion of elderly living alone also increased with advancing age in both urban and rural areas. For example, In 2010, the proportion of elderly living alone in urban areas was 4.1% for the 60-64 years age group, 5.5% for those 65–69, 12.2% for those 70–74, 13.1% for those 75–79, 16.2% for those 80–84, and 17.3%.for the group aged 85 years and over.

**Table 13: Elderly Living Alone, by Sex and Place of Residence, 2010**

| Sex | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| Male | 2.09 | 5.5 | 4.33 | 8.9 | 6.42 | 7.4 |
| Female | 4.64 | 11.6 | 6.20 | 12.3 | 10.84 | 12.0 |
| **Total** | **6.73** | **8.6** | **10.53** | **10.6** | **17.26** | **9.7** |

* In millions.

46. **The elderly living alone were predominantly widows, frequently in poor health, and living on very low income.** In 2010, 79.1% of the elderly living alone were widowed, 32.4% with a limitation in one or more activities of daily living, and 43% living in special financial difficulties. Older people living alone were also at risk of experiencing loneliness and social isolation (45.3% in 2010). These figures indicated that living alone could signify difficulties in arranging assistance when needed, particularly for informal support, and that older people living alone are more likely to need outside assistance in relation to illness or disability.

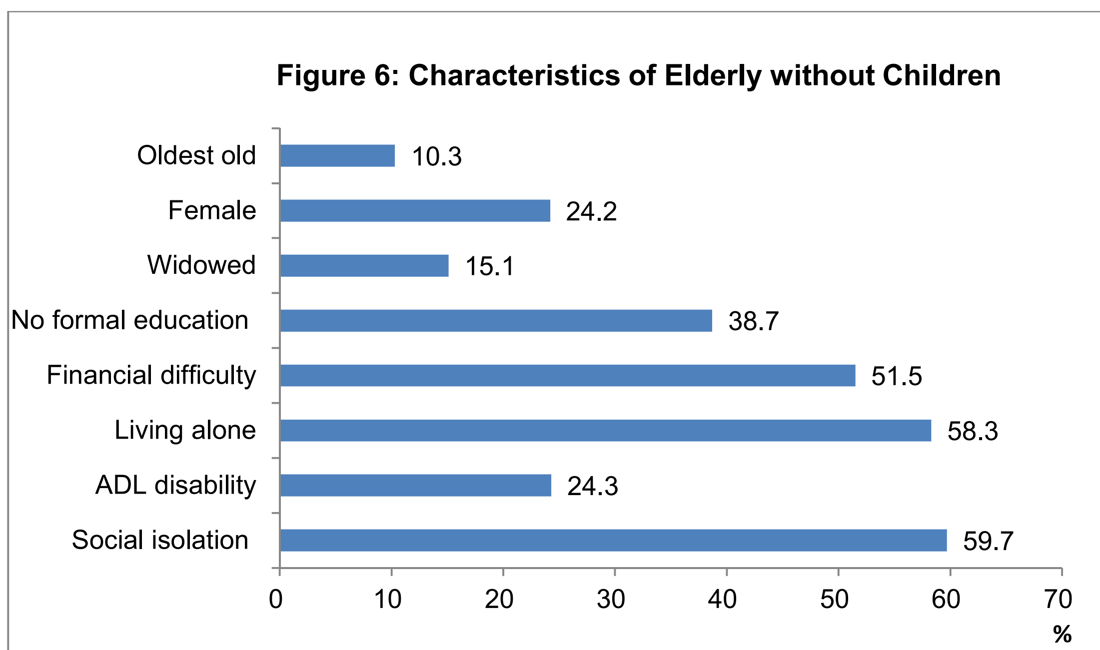



47. Although the number of elderly without living children is small at present, they experience multiple difficulties such as severe financial difficulty (51.5% in 2010). Moreover, most lack family support and a social network. In 2010, almost 60% of the elderly without any children lived alone and 60% were at risk of social isolation. If these elderly experience a serious illness or disability, they are dependent on external support. However, their social and medical needs are often not met due to financial difficulties and their lack of social network. Thus, public services are needed to assist the elderly without any child(ren).

**Table 14: The Elderly without Living Children, by Sex and Place of Residence, 2010**

| Sex | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| Male | 0.74 | 1.9 | 1.85 | 3.8 | 2.58 | 3.0 |
| Female | 0.38 | 0.9 | 0.45 | 0.9 | 0.82 | 0.9 |
| **Total** | **1.11** | **1.4** | **2.29** | **2.3** | **3.41** | **1.9** |

* In millions.




### 4. Elderly with ADL Disability

48. For most older people, being able to do everyday activities is a significant component of healthy aging.[19] [20] Life expectancy in the PRC has increased over the past several decades and recent cohorts of elderly are healthier than their preceding cohorts.[21] [22] [23] However, ADL disability still remains a common problem among older people, and the absolute number of older adults experiencing ADL disability is expected to increase with growth in the overall elderly population.

**Table 15: Elderly with ADL Disability, by Sex and Place of Residence, 2010**

| Sex | Urban | | Rural | | Total | |
|---|---|---|---|---|---|---|
| | No.* | % | No. | % | No. | % |
| Male | 5.63 | 14.7 | 11.11 | 22.8 | 16.74 | 19.2 |
| Female | 8.52 | 21.3 | 15.01 | 29.8 | 23.53 | 26.0 |
| **Total** | **14.15** | **18.1** | **26.12** | **26.3** | **40.27** | **22.7** |

* In millions.

49. In 2010, about 40 million elderly (23% of older persons), had ADL disability defined as a limitation in one or more of six activities of daily living (Table 15). The prevalence of ADL disability was markedly higher for older women than for older men (26.0% vs 19.2%), and for

[19] Menec, V. 2003.The relation between everyday activities and successful aging: A 6-year longitudinal study. *Journal of Gerontology: Social Sciences.* 58B (2), S74–S82.
[20] Phelan, E,, Anderson, L., LaCroix, A., and Larson, E. 2004. Older adults' views of "successful aging": How do they compare with researchers' definitions? *Journal of the American Geriatrics Society.* 52:211–216.
[21] Saito, Y., Qiao, X. and Jitapunkul, S. 2003. Health expectancy in Asian countries. In J.M. Rabine, C. Jagger, C. D. Mathers, E. M. Crimmins, & R. M. Suzman (Eds.), *Determining Health Expectancies*. Hoboken, New Jersey. Wiley. pp. 287–317.
[22] Gu D, Dupre ME, Warner DF and Zeng Y. 2009. Changing health status and health expectancies among older adults in China: Gender differences from 1992 to 2002. *Social Science and Medicine*. 68(12): 2170–2179.
[23] Liu J, Chen G, Song X, Chi I & Zheng X. 2009. Trends in disability-free life expectancy among Chinese older adults. *Journal of Aging and Health,* 21(2):266–285.

rural than for urban elderly (26.3% vs 18.1%). This prevalence increased significantly with advancing age. In 2010, about 10.5% of the elderly aged 60 to 64 had ADL disability (Figure 7). This rate increased to approximately 15% for the elderly aged 65 to 69 years. For the elderly aged 70 to 74 years, 26% experienced ADL disability, and this percentage rose to about 70% for adults aged 85 and older.

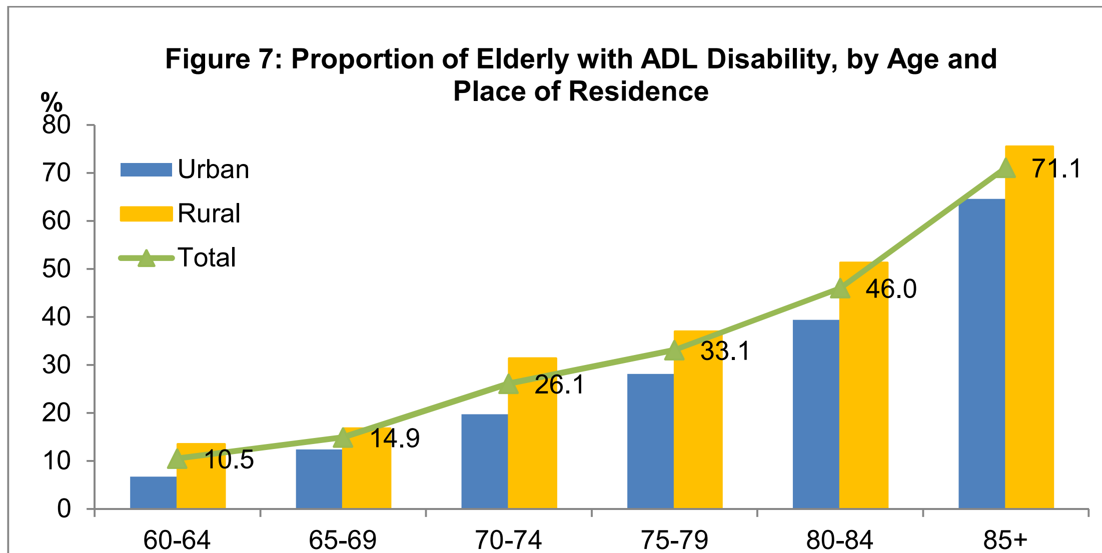


**Figure 7: Proportion of Elderly with ADL Disability, by Age and Place of Residence**

50. The elderly with ADL disability are usually characterized by living on low or very low incomes, and with very low levels of education and informal support. This is because there is an inverse socioeconomic gradient in the prevalence of ADL disability among both the urban and rural elderly. This means that prevalence increases significantly with decline in educational level (or self-rated economic status).[24] In 2010, nearly 50% (47.5%) of the PRC elderly with ADL disability lived in special financial difficulties, 50.9% had no formal education, and 48.2% were at risk for social isolation (Figure 8).

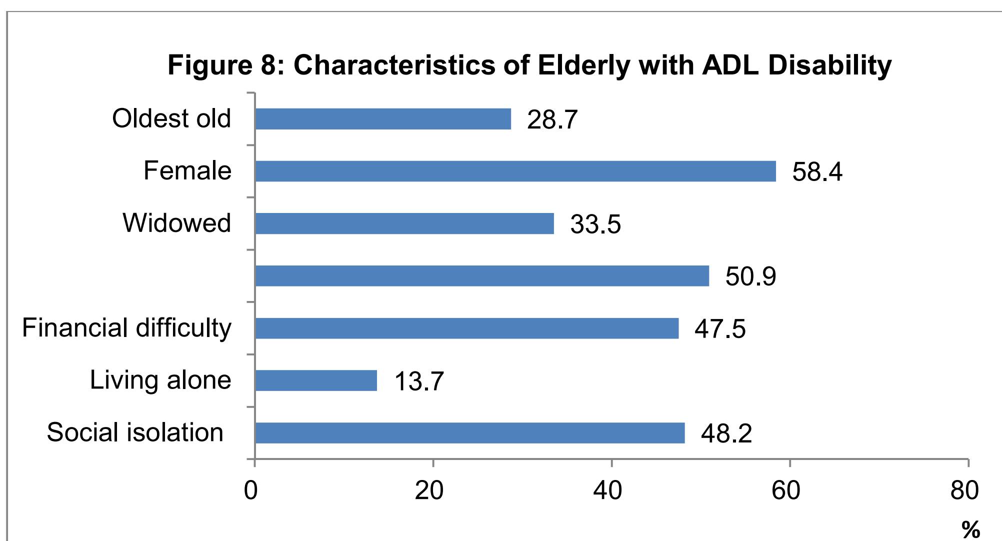


**Figure 8: Characteristics of Elderly with ADL Disability**

[24] Zhou, L. 2012. The association between SES and ADL dependence among elderly Chinese. *Population and Development*. 18(3):82–86.

## E. Health and Functional Status of the Elderly with Special Difficulties

51. This section discusses the health and functional status of ESD, including their self-rated health, the presence of chronic diseases and comorbid conditions, levels of ADL disability, IADL disability, hearing and vision impairments, incontinency and depression.

### 1. Self-rated Health

52. Self-rated health measures indicate overall general health status and an elderly individuals' own assessment of their health according to their own definition.[25] In 2010, 24.0% of the surveyed PRC elderly regarded their health as good or very good, 51.6% as fair, and 24.4% as bad or very bad. The proportions of elderly that perceived their health to be bad or very bad were higher in rural than urban areas and higher for women than for men (Figure 9).

53. Male and female ESD in all categories perceived their health to be significantly worse than their non-ESD peers (Table 16). These differences were most pronounced between the oldest old and the young old, for the elderly with and without financial difficulties and the elderly with and without ADL disability. For example, about 40% of the oldest old, 43.6% of the elderly with severe financial difficulty, and 55.4% of the elderly with ADL disability perceived their health to be bad or very bad, compared with 22.4% for the young old, 15.7% of the elderly without severe financial difficulty, and 15.3% of the elderly without ADL disability.

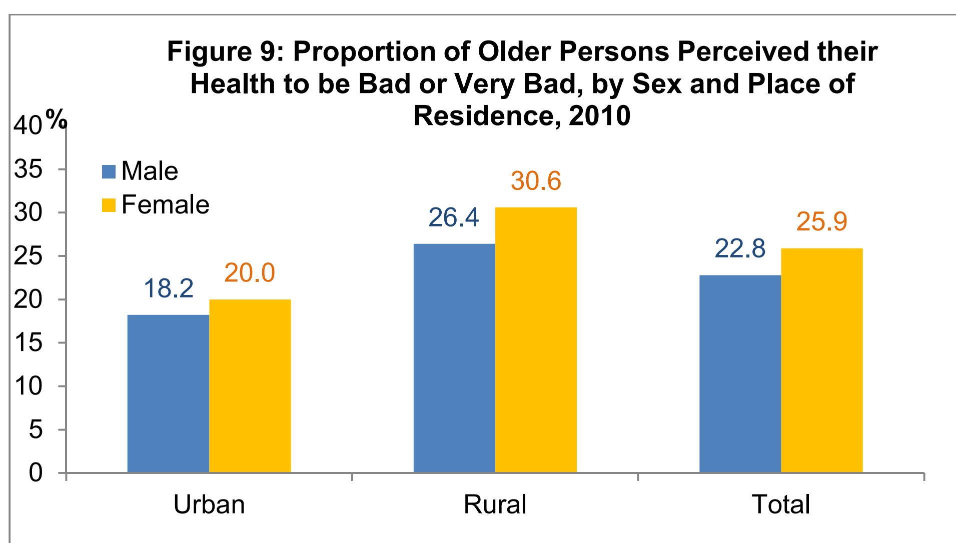



**Figure 9: Proportion of Older Persons Perceived their Health to be Bad or Very Bad, by Sex and Place of Residence, 2010**

**Table 16: Self-rated Health by Sex and ESD Characteristics**

| ESD Characteristics | Perceiving their Health to be Bad to Very Bad (%) | | |
|---|---|---|---|
| | **Male** | **Female** | **Total** |
| Oldest old | *** | *** | *** |
| Yes | 38.3 | 40.5 | 39.5 |
| No | 21.1 | 23.6 | 22.4 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 45.2 | 42.2 | 43.6 |
| No | 13.4 | 18.0 | 15.7 |

[25] Snead, Christine M. 2007. Self-rated health. *Blackwell Encyclopedia of Sociology*. pp. 31–33.

| ESD Characteristics | Perceiving their Health to be Bad to Very Bad (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Living alone | ** | *** | *** |
| Yes | 26.8 | 30.3 | 29.0 |
| No | 22.5 | 25.3 | 23.9 |
| Without children | ** | | * |
| Yes | 30.0 | 29.5 | 29.9 |
| No | 22.6 | 25.9 | 24.3 |
| ADL disability | *** | *** | *** |
| Yes | 56.7 | 54.4 | 55.4 |
| No | 14.8 | 15.9 | 15.3 |

Note: *P<0.05; ** P<0.01; ***P<0.00.1

### 2. Chronic Disease and Co-morbidity

54. The PRC has undergone rapid demographic and epidemiological changes over the past several decades and chronic diseases have become the leading causes of disability and mortality[26]. This is more visible in older age. In 2010, 120.63 million older people, or 67.9% of all elderly, had at least one chronic disease. Prevalence of chronic diseases was 74.4% for the urban and 62.6% for the rural elderly and was markedly higher for older women than older men (70.4% vs 65.3%) (Figure 10).

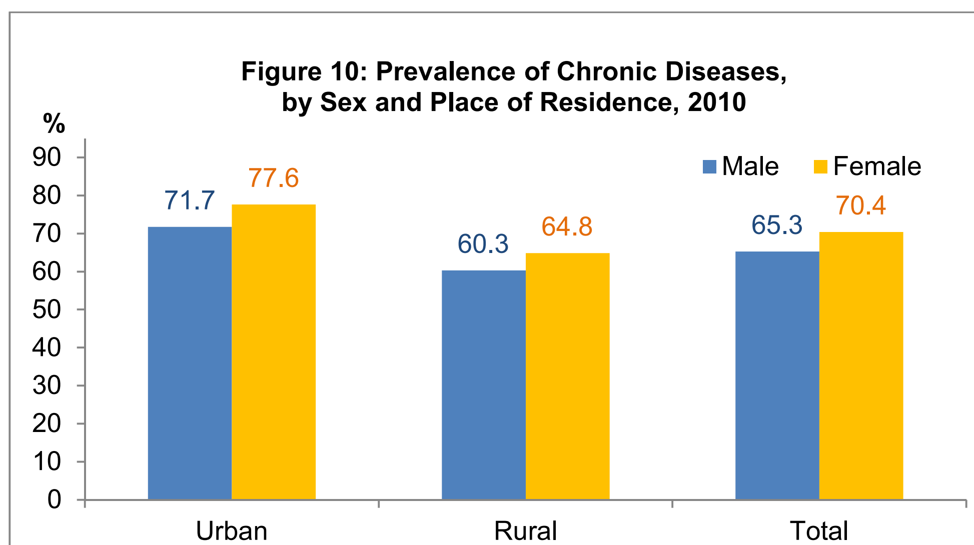



**Table 17: Prevalence Rates of Selected Known Chronic Diseases, by Age, 2010**

| Diseases | Prevalence (%) | | |
|---|---|---|---|
| | <80 | >80 | Total |
| Hypertension | 33.3 | 37.7 | 33.8 |
| Heart diseases | 19.1 | 22.4 | 19.5 |
| Cerebrovascular diseases | 10.8 | 13.3 | 11.1 |
| Diabetes mellitus | 7.3 | 7.3 | 7.3 |
| Cancer/tumor | 1.6 | 1.0 | 1.5 |

[26] Yang G, Wang Y, Zeng Y, et al. 2013. Rapid health transition in China, 1990–2010: Findings from the Global Burden of Disease Study 2010. *Lancet.* 381:1987–2015.

| Diseases | Prevalence (%) | | |
|---|---|---|---|
| | <80 | >80 | Total |
| Dementia | 1.1 | 7.1 | 1.8 |
| Parkinson's disease | 0.8 | 1.0 | 0.8 |
| Chronic bronchitis | 10.5 | 14.6 | 11.0 |
| Kidney diseases | 3.1 | 2.4 | 3.0 |
| Liver diseases | 2.4 | 1.0 | 2.2 |
| Urinary system diseases | 1.7 | 2.1 | 1.8 |
| Arthritis | 21.7 | 22.2 | 21.8 |
| Osteoporosis | 10.2 | 12.2 | 10.4 |
| Cervical or lumbar spondylosis | 17.5 | 13.1 | 17.0 |
| Glaucoma or cataract | 7.6 | 12.4 | 8.2 |

55. Table 17 describes the prevalence of chronic diseases for the elderly in 2010. Hypertension was the most common condition (33.8%), followed by arthritis (21.8%) and heart diseases (19.5%). Dementia was the chronic condition with the highest disabling impact[27] [28]. The prevalence rates for dementia were 1.1% for the 60–79 years age group and 7.1% for those aged 80 and over.

56. The prevalence of chronic diseases was significantly higher for the oldest old, the elderly with special financial difficulties, and the elderly with ADL disability than for their peers. Table 18 indicates a prevalence of chronic disease of 74.7% for both the oldest old and the elderly with special financial difficulties in 2010, compared with 67.0% for the young old and 64.8% for the elderly without severe financial difficulty. The highest rate was for the elderly with ADL disability (83.4%), which was significantly above that for the elderly without ADL disability (63.3%).

**Table 18: Prevalence Rates of Chronic Diseases by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of Chronic Diseases (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Oldest old | *** | *** | *** |
| Yes | 72.7 | 76.2 | 74.7 |
| No | 64.5 | 69.5 | 67.0 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 72.8 | 76.3 | 74.7 |
| No | 62.1 | 67.6 | 64.8 |
| Living alone | | | |
| Yes | 64.6 | 70.5 | 68.3 |
| No | 65.4 | 70.4 | 67.9 |
| Without children | | | * |
| Yes | 61.2 | 64.0 | 61.8 |
| No | 65.4 | 70.5 | 68.0 |
| ADL disability | *** | *** | *** |
| Yes | 82.5 | 84.1 | 83.4 |
| No | 61.2 | 65.5 | 63.3 |

Note: *P<0.05; ** P<0.01; ***P<0.001.

[27] Australian Institute of Health and Welfare. 2007. *Older Australian at a glance: 4th edition*. Cat. no. AGE 52. Canberra: AIHW. p. 176.

[28] Song X, Zhou Y, Guo P, et al. 2016. An analysis on disabling impacts of chronic diseases in Chinese elderly. *Population and Development*. p.3:

57. As chronic diseases tend to accumulate, many elderly are likely to experience comorbidity, that is, the presence of two or more chronic diseases at the same time. Comorbidity has a significant impact in older age.[29] [30] The impact of comorbidity on functioning and quality of life may be significantly greater than the sum of individual effects that might be expected from these conditions. As the number of chronic diseases increases, so do the risks of experiencing ADL disability. Predictably, comorbidity is also associated with higher rates of health care utilization.

58. Comorbidity affected 42.0% of PRC elderly in 2010 and was more prevalent in the vulnerable elderly and the elderly with low social economic status.[31] The prevalence of comorbidity was 48.0% for the oldest old, 48.5% for the elderly with special financial difficulties and 56.5% for the elderly with ADL disability (Table 19). However, there were no significant differences in the prevalence of comorbidity between the elderly living alone and those living with others or between the childless elderly and those with children. In addition, the prevalence of comorbidity among the elderly with ESD characteristics was higher for women than men. This was also the case among the elderly without ESD characteristics.

**Table 19: Prevalence of Comorbidity by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of Comorbidity (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Oldest old | *** | * | *** |
| Yes | 46.8 | 48.9 | 48.0 |
| No | 36.9 | 45.5 | 41.2 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 44.6 | 51.9 | 48.5 |
| No | 35.1 | 43.0 | 39.1 |
| Living alone | | * | |
| Yes | 36.5 | 42.7 | 40.4 |
| No | 38.0 | 46.4 | 42.2 |
| Without children | | | * |
| Yes | 28.2 | 52.3 | 33.8 |
| No | 38.2 | 45.9 | 42.2 |
| ADL disability | *** | *** | *** |
| Yes | 54.0 | 58.4 | 56.5 |
| No | 34.2 | 41.5 | 37.7 |

Note: *P<0.05; ** P<0.01; ***P<0.001

### 3. ADL Disability

59. The measurement of ADLs can be useful in identifying the need for social care. As mentioned in Section 4, about 40 million PRC elderly (23%) had ADL disability in 2010. However, ADL disability does not occur randomly among older people. Instead, it increases significantly with advancing age and is significantly higher for disadvantaged subgroups of older people. The elderly with financial difficulty reported higher ADL disability than those without

[29] WHO. 2015. *World report on ageing and health*. World Health Organization. pp. 58–61.

[30] Marengoni A, Angleman S, Melis R, et al. 2011. Aging with multimorbidity: a systematic review of the literature. *Ageing Resources Review*. 10(4):430–9.

[31] Wang H.H, Wang J.J, Wong S.Y, et al. 2014. Epidemiology of multimorbidity in the PRC and implications for the healthcare system: A cross-sectional survey among 162,464 community household residents in southern China. *BMC Medicine*. 12(1):188.

financial difficulty (34.6% vs 17.2%). 32.4% of the elderly living alone had ADL disability compared with only 21.6% for the elderly living with others (Table 20). No significant difference in ADL disability was found between the childless elderly and the elderly with children. This same pattern held for the prevalence of severe ADL disability, as shown in Table 21. For example, 11.3% of the elderly with severe financial difficulty had severe ADL disability compared with only 4.7% for the elderly without severe financial difficulty.

**Table 20: Prevalence of ADL Disability by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of ADL Disability (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Oldest old | *** | *** | *** |
| Yes | 47.3 | 60.6 | 55.0 |
| No | 16.1 | 20.6 | 18.3 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 31.8 | 37.1 | 34.6 |
| No | 14.0 | 20.5 | 17.2 |
| Living alone | *** | *** | *** |
| Yes | 26.5 | 35.9 | 32.4 |
| No | 18.6 | 24.7 | 21.6 |
| Without children | | ** | |
| Yes | 19.1 | 41.2 | 24.3 |
| No | 19.2 | 25.9 | 22.6 |

Note: *P<0.05; ** P<0.01; ***P<0.001.

**Table 21: Prevalence of Severe ADL Disability by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of severe ADL disability (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Oldest old | *** | *** | *** |
| Yes | 16.0 | 27.5 | 22.7 |
| No | 4.5 | 4.9 | 4.7 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 9.5 | 12.9 | 11.3 |
| No | 4.0 | 5.4 | 4.7 |
| Living alone | | *** | *** |
| Yes | 7.0 | 10.8 | 9.4 |
| No | 5.5 | 7.6 | 6.5 |
| Without children | | *** | |
| Yes | 3.6 | 9.2 | 4.9 |
| No | 5.7 | 7.9 | 6.9 |

Note: *P<0.05; ** P<0.01; ***P<0.001.

60. Tables 20 and 21 also reveal that prevalence of both ADL disability and severe ADL disability were markedly higher for women than for men among ESD. For example, 27.5% of the female oldest old had severe ADL disability compared with 16.0% for the male oldest old.

### 4. IADL Disability

61. The elderly with normal ADL scores cannot guarantee that they can live independently. The ability to live independently also means having the ability to perform instrumental activities

of daily living (IADL). Among all PRC elderly, these prevalence rates were 46.3% for IADL disability and 26.4% for IADL severe disability in 2010.

**Table 22: Prevalence of IADL Disability by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of IADL Disability (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Oldest old | *** | *** | *** |
| Yes | 77.6 | 87.6 | 83.4 |
| No | 36.7 | 46.0 | 41.3 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 57.9 | 66.8 | 62.7 |
| No | 33.6 | 43.9 | 38.7 |
| Living alone | *** | *** | *** |
| Yes | 50.3 | 60.5 | 56.7 |
| No | 40.0 | 50.4 | 45.2 |
| Without children | ** | | * |
| Yes | 48.6 | 61.2 | 51.5 |
| No | 40.6 | 51.5 | 46.2 |
| ADL disability | *** | *** | *** |
| Yes | 94.6 | 97.3 | 96.2 |
| No | 35.6 | 28.0 | 31.7 |

Note：*P<0.05; ** P<0.01; ***P<0.001

**Table 23: Prevalence of IADL Severe Disability by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of IADL with Severe Disability (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Oldest old | *** | *** | *** |
| Yes | 50.2 | 65.3 | 59.0 |
| No | 20.5 | 23.6 | 22.1 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 36.6 | 39.7 | 38.2 |
| No | 18.1 | 24.1 | 21.1 |
| Living alone | * | *** | *** |
| Yes | 27.0 | 36.4 | 32.9 |
| No | 23.2 | 28.3 | 25.7 |
| Without children | * | | * |
| Yes | 29.7 | 36.5 | 31.3 |
| No | 23.3 | 29.2 | 26.3 |
| ADL disability | *** | *** | *** |
| Yes | 68.3 | 67.5 | 67.8 |
| No | 12.9 | 15.9 | 14.3 |

Note：*P<0.05; ** P<0.01; ***P<0.001

62. In general, the loss of IADL capacity precedes the loss of ADL. Consequently, almost all the elderly with ADL disability suffered some degree of IADL disability. In 2010, 96.2% of the elderly with ADL disability also had IADL disability and 67.8% had severe IADL disability. Tables 22 and 23 indicate that prevalence of IADL disability and IADL severe disability were much higher for ESD. For example, in 2010, prevalence rates for IADL disability and severe disability

of the elderly with financial difficulty were 62.7% and 38.2% respectively, significantly higher than for IADL without financial difficulties (38.7%) and severe disability (21.1%). Among ESD, the prevalence of both IADL disability and severe IADL disability were markedly higher for women than men.

### 5. Sensory Functions

63. Changes in sensory functions can have important implications for the everyday lives of the elderly. Hearing impairment affects communication and can contribute to social isolation, with associated anxiety, depression, and cognitive decline.[32] Visual impairments can limit mobility, affect interpersonal interactions, trigger depression, become a barrier to accessing information, and increase the risk of falls and accidents.[33]

**Table 24: Prevalence of Hearing Impairment by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of Hearing Impairment (%) | | |
|---|---|---|---|
| | **Male** | **Female** | **Total** |
| Oldest old | *** | *** | *** |
| Yes | 43.0 | 53.1 | 48.9 |
| No | 26.0 | 33.2 | 29.6 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 40.1 | 47.4 | 44.0 |
| No | 22.8 | 30.7 | 26.7 |
| Living alone | *** | *** | *** |
| Yes | 35.4 | 43.3 | 40.3 |
| No | 27.1 | 34.9 | 31.0 |
| Without children | | *** | |
| Yes | 30.1 | 43.5 | 33.2 |
| No | 27.7 | 35.8 | 31.9 |
| ADL disability | *** | *** | *** |
| Yes | 46.8 | 54.6 | 51.4 |
| No | 23.2 | 29.2 | 26.1 |

Note: *P<0.05; ** P<0.01; ***P<0.001.

64. Tables 24 and 25 indicate prevalence of hearing and visual impairments by sex and ESD characteristics. Hearing impairment affected 20.0% of surveyed PRC elderly and visual impairment 31.9%. Both hearing and visual impairment were much more prevalent among elderly with ESD characteristics, other than for the elderly without any children. Similar to hearing impairment, the highest rates of visual impairment were for the oldest old (48.9%) and the elderly with ADL disability (51.4%). Significant differences were also found between the elderly with and without financial difficulty (44.0% vs 26.7%) and between those living alone and not living alone (40.3% vs 31.0%). A very similar pattern was evident for visual impairment (Table 25).

[32] Parham K, McKinnon BJ, Eibling D, Gates GA. 2011. Challenges and opportunities in presbycusis. *Otolaryngol Head Neck Surgery.* 144(4):491–5.

[33] Turano K, Rubin GS, Herdman SJ, Chee E, Fried LP. 1994. Visual stabilization of posture in the elderly: fallers vs. nonfallers. *Optometry Visual Science*. 71(12):761–9.

**Table 25: Prevalence of Visual Impairment by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of Visual Impairment (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Oldest old | *** | *** | *** |
| Yes | 42.5 | 47.8 | 45.6 |
| No | 17.1 | 16.0 | 16.6 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 28.1 | 29.0 | 28.6 |
| No | 16.3 | 16.2 | 16.3 |
| Living alone | * | *** | *** |
| Yes | 23.1 | 29.6 | 27.2 |
| No | 19.4 | 19.0 | 19.2 |
| Without children | | *** | |
| Yes | 22.8 | 21.6 | 22.5 |
| No | 19.6 | 20.3 | 20.0 |
| ADL disability | *** | *** | *** |
| Yes | 40.4 | 41.5 | 41.0 |
| No | 14.8 | 12.8 | 13.8 |

Note: *P<0.05; ** P<0.01; ***P<0.001.

65. Among ESD, the prevalence of hearing impairment was markedly higher for women than men (Table 24). Moreover, the prevalence of visual impairment was higher for the female oldest old than for their male peers, and higher for those female elderly living alone than for their male peers (Table 25).

### 6. Incontinence

66. Incontinence can severely affect the quality of life for both older people and their caregivers. It has been associated with depression among older people[34] and increased strain and burden for their caregivers.

67. The prevalence of incontinence increases with age and is much higher in the elderly with some ESD characteristics. Table 26 indicates that prevalence among the oldest old (14.2%) was nearly three times that for the young old (5.0%). An even greater difference was found between the elderly with and without ADL disability. In 2010, prevalence among the elderly with ADL disability was 15.3%, or nearly five times that for elderly without ADL disability (3.3%). Incontinence was also more common among the elderly on low incomes (10.1% compared with 4.3% for those without financial difficulty). Table 26 did not reveal any significant gender difference in incontinence. However, a systematic review indicated that urinary incontinence was much higher for women than men across all age groups.[35]

**Table 26: Prevalence of Incontinence by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of Incontinence (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Oldest old | *** | *** | *** |

[34] Sims J, Browning C, Lundgren-Lindquist B, Kendig H. 2011. Urinary incontinence in a community sample of older adults: prevalence and impact on quality of life. *Disability Rehabilitation.* 33(15-16):1389–98.

[35] Milsom I, Coyne KS, Nicholson S, et al. 2014> Global prevalence and economic burden of urgency urinary incontinence: a systematic review. *European Urology.* 65(1):79–95.

| ESD Characteristics | Prevalence of Incontinence (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Yes | 13.3 | 14.8 | 14.2 |
| No | 5.1 | 4.9 | 5.0 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 10.0 | 10.2 | 10.1 |
| No | 4.3 | 4.3 | 4.3 |
| Living alone | | | |
| Yes | 5.9 | 6.2 | 6.5 |
| No | 5.9 | 6.9 | 6.0 |
| Without children | * | | ** |
| Yes | 3.0 | 2.4 | 2.9 |
| No | 6.0 | 6.3 | 6.1 |
| ADL disability | *** | *** | *** |
| Yes | 16.7 | 14.3 | 15.3 |
| No | 3.2 | 3.5 | 3.3 |

Note: *P<0.05; ** P<0.01; ***P<0.001.

**Table 27: Prevalence of Depression by Sex and ESD Characteristics**

| ESD Characteristics | Prevalence of Depression (%) | | |
|---|---|---|---|
| | Male | Female | Total |
| Oldest old | * | *** | *** |
| Yes | 25.2 | 39.0 | 33.3 |
| No | 22.0 | 22.4 | 22.2 |
| Severe financial difficulty | *** | *** | *** |
| Yes | 46.2 | 42.8 | 44.4 |
| No | 12.3 | 15.8 | 14.0 |
| Living alone | * | *** | *** |
| Yes | 36.2 | 32.5 | 33.9 |
| No | 21.2 | 23.6 | 22.4 |
| Without children | *** | * | *** |
| Yes | 52.0 | 33.3 | 47.7 |
| No | 21.4 | 24.5 | 23.0 |
| ADL disability | *** | *** | *** |
| Yes | 45.6 | 46.1 | 45.9 |
| No | 16.8 | 17.1 | 16.9 |

Note: *P<0.05; ** P<0.01; ***P<0.001.

### 7. Depression

68. Depression is a common mental health problem in later life. Results from a study conducted in four PRC provinces from 2001–2005 showed that older adults were more likely to have a major depressive disorder (3.82%), than middle-aged (2.72%) or young adults (1.15%) respectively.[36] Furthermore, the prevalence of depressive symptoms was much higher than for major depressive disorders. These symptoms are associated with significant functional impairment, lower social support, and increased medical care utilization, similar to that seen in

[36] Phillips MR, Zhang J, Shi Q, et al. 2009. Prevalence, treatment, and associated disability of mental disorders in four provinces in the PRC during 2001–05: an epidemiological survey. *Lancet.* ,373:2041–2053.

major depression.[37] In the 2010 Sampling Survey of the Aged Population in the Rural/Urban PRC, the prevalence of depressive symptoms measured with the Geriatric Depression Scale-15 (GDS-15) was 23.5% for those aged 60 years or older.

69. Table 27 above presents the prevalence of depression (GDS-defined depression) by sex and ESD characteristics. Among the elderly, depression was more prevalent in the elderly with ESD characteristics, especially for those with special financial difficulties, without any children, or with ADL disability. For example, 44.4% of the elderly with financial difficulty had depression compared with 14.0% of those without financial difficulty. Among the oldest old, the prevalence of depression was markedly higher for women than for men (39.0% vs 25.2%).

### 8. Summary of Key Findings on ESD

#### a. Important Sociodemographic Characteristics of the PRC Elderly

(i) **Age and sex composition**: and The PRC had 178 million people aged 60 years and over in 2010. More than half (53.2%) were aged 60–69 years old, with about one-third (32.0%) aged 70–79 and 11.8% aged 80 years and over. Over the next few decades, the internal age structure of the elderly population will continue to change. This trend will directly affect the provision of elderly care. The number of elderly women is greater than that of elderly men and the proportion of elderly women increases with age.

(ii) **Marital status and household composition:** The majority (about 79%) of older people were married, but almost 20% were widowed and a very small proportion were divorced or had never married. The proportion of widowed increased with age, being 14.6% for the elderly under 80 years of age and 55.8% for those over 80. The marital status of men differed significantly from that of women. There was also a marked urban-rural difference in the marital status of older people, especially for the oldest old. In 2010, about 40% of all elderly lived with a spouse only and about 10% lived alone, i.e., close to 50% lived in "empty-nest" households. Another 50% lived with children (38.9%) or with others (11.8%). There was a significant urban-rural difference in living arrangements.

(iii) **Educational attainment:** The educational level of older people was very low, particularly in rural areas. About one-third of all elderly did not have any formal education. The proportions of elderly with no formal education were much higher for women (21.1% in urban and 62.1% in rural areas) than men (5.5% in urban and 30.4% in rural areas).

(iv) **Economic status:** About one third of elderly respondents self-evaluated their economic situation as lacking or severely lacking money. The rural elderly rated their economic situation worse than did the urban elderly.

#### b. Prevalence and Characteristics of the Elderly with Special Difficulties

(i) **Oldest old:** in 2010, the number of oldest old totaled 20.99 million, accounting for 11.8% of all older people. As baby boomers age, the oldest old will become the fastest-growing age group in the PRC. The oldest old generally require

[37] Hybels CF, Blazer DG and Pieper CF. 2001. Toward a threshold for sub threshold depression: an analysis of correlates of depression by severity of symptoms using data from an elderly community sample. *The Gerontologist.* 41 (3):357–365.

assistance. In 2010, more than half (55%) had a limitation in one or more activities of daily living; they were predominantly widows, with very low education level and frequently lived in social isolation in proportions significantly higher than for the elderly under 80 years old.

(ii) **The elderly in severe financial difficulty:** About 55 million elderly (31.2%) assessed themselves as living on inadequate or severely inadequate incomes in 2010. The proportion of rural elderly in severe financial difficulty was nearly two times that of those in urban areas. The elderly in severe financial difficulty experienced higher rates of ADL disability and social isolation than others of their age group. In 2010, about one-third of ESD had a limitation in one or more activities of daily living, and close half (50%) were at risk of social isolation.

(iii) **The elderly living alone:** In 2010, about 17 million elderly (9.7%) lived alone. Their numbers were higher in rural than urban areas (10.6% vs 8.6%), and considerably higher for older women than older men (12.0% vs 7.4%). The elderly living alone were predominantly widows, frequently in poor health, and living on very low incomes. In 2010, 79.1% of the elderly living alone were widowed, 32.4% experienced limitation in one or more activities of daily living, and 43% lived in severe financial difficulty. Older people who lived alone were also at risk of experiencing loneliness and social isolation.

(iv) **The elderly without children:** In 2010, about 3.4 million elderly, or about 2% of the elderly population, did not have any children alive. Although the elderly without any living children is a relatively small number at present, they experience multiple difficulties. They often live in severe financial difficulty (51.5% in 2010) but most lack the support of family and a social network. In 2010, close to 60% of the elderly without children lived alone and 60% were at risk of social isolation.

(v) **The elderly with ADL disability:** In 2010, about 40 million elderly (23%) had ADL disability (a limitation in one or more of six activities of daily living). The prevalence of ADL disability was markedly higher for older women than for older men at 26.0% vs 19.2%, and higher for the rural than urban elderly (26.3% vs 18.1%). The elderly with ADL disability were frequently living on low to very low incomes, with very low levels of education and little informal support. In 2010, nearly 50% of all elderly lived in severe financial difficulty, with about half having no formal education and 50% being at risk of social isolation.

### c. Health and Functional Status and Care Needs of the Elderly with Special Difficulties

(i) **The ESD self-evaluated their health as poor** and their prevalence rates of chronic diseases, comorbidity, ADL disability, IADL disability, hearing impairment, visual impairment, incontinence and depression were significantly higher than for non-ESD.

(ii) **There were significant gender differences in health and functional status of ESDs** and the prevalence of chronic diseases, comorbidity, ADL disability, IADL disability, and hearing impairment were much higher for female than male ESD.

(iii) **The ESD have multiple and complex needs.** These include financial assistance, personal care, housekeeping services, health care services (such as home nursing services, home health visits, and rehabilitation services) and psychosocial support.

## F. Care Needs and Social Work Services for the Elderly with Special Difficulties

### 1. Care Needs of ESD

70. The analysis above indicates that ESD are characterized by high levels of widowhood, living alone, low levels of education; low self-rated health and a significantly higher prevalence of chronic disease, comorbidity, ADL disability, IADL disability, hearing and visual impairments, incontinence, and depression. Moreover, they often live in poverty or experience low incomes and levels of social support. These results indicate that ESD usually have multiple and complex needs that are not just financial, including

- (i) **personal care:** assistance with self-care activities; e.g., eating, dressing, toiletry, and bathing;
- (ii) **housekeeping services:** assistance with instrumental activities of daily living; e.g., cooking, shopping, laundry, transportation, financial management, and telephone use;
- (iii) **health care services:** such as home nursing services, home health visits, and rehabilitation services; and
- (iv) **psychosocial support.**

### 2. Social Work Services for ESD

71. Social workers for the elderly provide a wide range of professional services, including needs assessments, helping the elderly to deal with crises, providing case management services to address multiple needs of the elderly, helping the elderly solve problems in their daily lives, assisting the elderly to take on changing roles associated with aging, providing social support for those elderly at risk of social isolation, and helping the elderly cope with death, bereavement, and other major life events. For example, social workers in Hong Kong, China take the lead in elderly care assessment.

72. In January, 2016, the PRC Ministry of Civil Affairs issued *Guidelines for Elderly Social Work Service*, which specified twelve service areas and details for elderly social work services. Elderly social work services are described along a micro to macro continuum with; (1) direct service at the micro level; (2) elderly care service management, resource integration, and linkages at the mezzo-level; and (3) policy advocacy at the macro level. In this continuum, each specific point consists of multiple dimensions, such as material assistance, psychological intervention, and the promotion of social functions.

73. This report has drawn on these *Guidelines*, the needs analysis conducted for the report, and interviews undertaken with administrators of relevant elderly care service agencies, to recommend that social work services for the ESD should include the following four aspects:

- (i) **A needs assessment and resource mechanism** to help ESD access government and various social resources; to assist in the organization or coordination of other professional organizations and volunteers to provide the needy ESD with home health care, personal care, spiritual care, hospice care, health promotion, respite care and home modification, etc.
- (ii) **Psychological support and crisis intervention** to help ESD to overcome psychological problems such as depression, anxiety and loneliness, prevent suicide and other critical life-threatening events, and rebuild confidence and hope in life.
- (iii) **Services for ability upgrading and social integration** to assist ESD to acquire abilities to cope with difficulties and adapt themselves within society, to

reconstruct their social support network, enrich their social life, and promote equal participation and integration into society.

(iv) **Advocacy and protection of rights and interests** to help ESD understand relevant laws, regulations, and social policies concerning the elderly and information on elderly services and resources, to protect ESD from discrimination, insult and other unfair or unreasonable treatment, to improve laws, regulations and social policies for the elderly, and to maintain and safeguard the rights and interests of ESD.

74. Details on social work services for ESD are provided in the third section of the *Guidelines.* The following are policy level recommendations for social work services for ESD.

### a. Policy Recommendation 1: Bundled Service Strategies should be Adopted to Provide Social Work Services for ESD

75. ESD frequently have multiple difficulties and complex needs that involve long-term care and require a variety of resources. However, those in most need often have the least resources available to address their problems. Their financial difficulties and lack of care resources result in their social and health service needs often being unmet. It is recommended that bundled service strategies be adopted for social work services and service methods in order to include direct intervention (case work and group work) together with case management, community development and social policy, and stronger interdisciplinary and cross sectoral-cooperation.

76. Social workers should not only be responsible for, but also work as, gate keepers and join the ESD care and service team to enhance multidisciplinary cooperation. This can improve services and care for ESD and their families through more effective communication, collaboration and information sharing between professionals from different disciplines.

### b. Social Work Services for ESD should be Gender Sensitive and Responsive

77. There are significant gender differences in the health and functional status of the elderly. Findings from this report show that even among ESD, differences still exist. For example, among the elderly with financial difficulties, female prevalence rates for comorbidity (51.9%) and ADL disability (37.1%) were significantly higher for males (44.6% and 31.8%); and female prevalence rates among the oldest old for ADL disability (60.6%), hearing impairment (53.1%), and depression (39%) were significantly higher than those for males at 47.3%, 43% and 25.2% respectively. Moreover, this gender health difference went far beyond biological aspects. Gender also affected availability of various resources. Therefore, social work services for ESD should adopt a gender perspective and give special attention to the plight of the female elderly in terms of social, cultural, economic, political, and environmental aspects.

### c. Social Work Services for ESD should Pay Special Attention to Mental Health Problems

78. The elderly population, and particularly the poverty-stricken elderly, are at high risk of mental health problems. Research results showed that the prevalence of depression among the elderly with financial difficulties was 44.4%, or about 3.2 times higher than that for the elderly without financial difficulties. Depression among the elderly living alone was 33.9%, (about 1.5 times higher than that of the elderly living with others), 47.7%, (about 2.1 times higher) for the elderly without children compared to those with children; and 45.9% (about 2.7 times higher) for

the elderly with ADL disability than without. It is worth noting that the prevalence of depression among the oldest old was significantly higher than that of the younger elderly, which largely related to the presence of chronic diseases, ADL disability, and lower levels of social support. Psychological and social support services are therefore a key element for the elderly, and particularly for ESD.

# II. GOOD PRACTICES IN SOCIAL WORK SERVICE DELIVERY MODES FOR THE ELDERLY IN SPECIAL DIFFICULTIES

## A. Introduction

79. With accelerated population aging, care services for the elderly have become one of the most pressing issues in contemporary PRC society. It is also a core area in which social workers can play an important role. This makes strengthening elderly social work an essential component for building a modern elderly care service system.

80. Care services for the elderly should be equally available to all elderly people, but priority should be given to ESD to ensure fairness and justice. More efforts should be made to solve problems in delivering care services to those elderly experiencing special physical, psychological, and/or financial difficulties, and priority toward ensuring that their basic service needs are met. This is both a focus and challenge for PRC elderly care services. The need to integrate social work into services provided to ESD is urgent. Methods such as government procurement of services can help to speed and promote the development of social work service institutions and social work services for ESD.

81. In 2014, PRC Ministry of Civil Affairs (MOCA) initiated a pilot project to provide ESD social work services. MOCA realized that a number of problems needed to be addressed during the promotion of community-based social work services and government procurement of social work services for ESD. In particular, a strong policy framework and guidelines for ESD social work services were urgently needed, together with strengthened government procurement mechanisms and incentive mechanisms to motivate social workers and volunteers.

82. This report provides recommendations on strengthening the policy environment, and improving service delivery modes, with an emphasis on standard guidelines, a broad implementation framework, and monitoring and evaluation systems. Research undertaken for the social work service delivery mode component is outlined below.

## B. Research Purpose, Content, and Methods

### 1. Research Purpose and Content

83. The social work service delivery mode for ESD refers to the service delivery arrangements during the delivery process and involves three sets of actors: government, service providers, and clients (ESD). This section of the report focuses on

(i) the evolution of elderly social work practice in the PRC;
(ii) strengths and weaknesses of current service delivery modes, focusing particularly on the government procurement mode;
(iii) major bottlenecks hampering delivery of ESD social work services;
(iv) identification of ways in which existing bottlenecks can be effectively addressed; and

(v) necessary policy and systems changes to promote the delivery of elderly social work services.

### 2. Research Methods

84. A literature review covered relevant reports, research papers, and articles on social work service delivery modes, and policy documents on elderly care services, professional social work, and government purchase of services. Field investigations aimed to explore the main obstacles to delivery of social work services and to identify good practices to overcome them.

## C. Development of PRC Social Work for the Elderly

### 1. The Embryonic Stage

85. This stage was characterized by public elderly care service institutions introducing professional social workers. Some cities then began to pilot home care services.

86. People in this period were influenced by the earlier care system and still understood elderly social care services as institution-based elderly care services. As a result, the government's major initiative in the reform of socialized elderly care service was to mobilize nongovernmental groups to build elderly care service institutions.[38] From 1998 to 2005, the State Council and other related departments issued eight policy documents on elderly care services, seven concerning construction and management of non-profit and nongovernmental elderly welfare institutions.

87. The development of elderly social work practice began in 2000. In August, the Communist Party of China Central Committee and the State Council jointly issued Decisions on Strengthening the Work for the Elderly that proposed to advance elderly care service mechanisms that were "family-based, with community services as the core support and services provided by social organizations as a complement". Under government guidance, Shanghai Municipality led the initial exploration of social work practice.[39] This initiated the reform of socialized elderly care services.

88. With government focusing on an institutional care model, the initial practice of social work for the aged mainly occurred in elderly care service institutions. Some public elderly care service institutions gradually began to introduce professional social workers. For instance, Shanghai No.1 Social Welfare Institution pioneered the involvement of professional social workers in 2000. In 2003, Beijing No.5 Social Welfare Institution also introduced professional social workers. In 2004, Beijing No.1 Social Welfare Institution became the first to set up a "social work department".[40] In 2005, Guangzhou Old People's Home opened a social work department that employed professional social workers and invited Hong Kong elderly care service experts as technical advisers.[41]

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[38] Tang Y and Xu YD. The development of non-profit and non-governmental organizations in the elderly services during the transition of social welfare in China. Journal of Shenzhen University (Humanities & Social Sciences), 2010, 27(1):74–78.

[39] Tang J. 2015. Government procurement of social work services: progress and prospects. *Social Construction.* (4):3–15.

[40] Social Work Research Center, Ministry of Civil Affairs. 2009. *Report on Social Work Development in China*. Social Science Academic Press (the PRC).

[41] Huang WK. 2007. Happiness Always, Charming Elderly—Social Work Department of Guangzhou Old People's Home. *Social Work.* (5S):38–39.

89. This stage of community elderly care service was still very weak and mainly limited to managing the transferred work unit files for retired personnel, their pension payments, and other welfare responsibilities.[42] However, the practice of home-based elderly care service and government procurement of elderly care also emerged. Shanghai Municipal Bureau of Civil Affairs undertook the first pilot home care service provision in 12 streets of six districts in 2000. The municipal government provided subsidies for home-based care service agencies and door-to-door services for ESD, such as the elderly on low incomes. Government procurement of home-based elderly care services was comprehensively implemented from 2001. In 2003, Shanghai municipal government standardized the elderly care service subsidy system and established a home-based care service voucher system as a demand side financing strategy.[43] Soon after this, the developed eastern cities of Nanjing[44] and Ningbo[45] and some other cities followed with their own pilot government procurement schemes. These focused on providing daily living care services for the 'empty nest' elderly, and those living alone or on low incomes. Home-based care in this period was basically limited to housekeeping services but it still laid the foundations for government procurement of social work services.

### 2. The Initial Stage

90. This stage was characterized by a changed policy environment for both elderly care and social work services. Elderly care service developed into a community care service model, and some areas began to explore a model for developing social work and government procurement of social services.

91. **Elderly care services.** In February 2006, the General Office of the State Council issued Opinions on Accelerating the Development of Elderly Care Services, which, for the first time, advanced the idea of "home-based" rather than the earlier "family-based" elderly care services. This was a turning point in socialized elderly care service reform in which the focus shifted from an institution-basis to a community-basis. Communities became the main locus for elderly care services and this change created (1) a growth space for nongovernmental home-based care service institutions, and also (2) built a practical platform for broader development of elderly social work.

92. 2006 was a crucial year for the development of social work because the Sixth Plenary Session of the 16th CPC Central Committee issued Decisions on Several Major Issues of Building a Harmonious Socialist Society. These decisions proposed to establish a comprehensive network of social work personnel to begin promoting social work development. Shortly thereafter, a series of policies and measures were released, including: (1) establishment of a social work professional qualification examination and registration system; (2) encouragement for government public service and social management departments to establish social work posts to attract professional social workers and to promote professionalized social services within the system; (3) exploration of a government procurement of social service mode to promote the development of nongovernment social work institutions outside the system.

[42] Chen SY. 2015. Social policies and aging in community: international and historical perspectives. *Reform and Strategy*. (2):157–167.

[43] Wang YY. 2015. Provision, finance and decision of home care for the elderly in Shanghai: The perspective of wheels of welfare. *Journal of East China University of Science and Technology: Social Science Edition*. 30(4):20–27.

[44] Fan WF, QI J, Xue MR et al. 2010. Government purchases of public services from CSOs on the Home-based aged-care services: A case of Gulou District in Nanjing. *Scientific Decision Making*. (4):19–30.

[45] Yu JX and Qu ZY. 2011. Intersubjective relationship of public-private partnerships---based on two case studies Of home-based aging care services. *Comparative Economic and Social Systems*. (4): 109–117.

These policies allowed social work, which had long been “a foreign discipline sealed in the ivory tower”, to rapidly become embedded in the social fabric of the PRC.[46]

93. Under government guidance, and with an orientation toward real needs, social work became a kind of institutional arrangement. Pilot work commenced and the Shenzhen model became very influential. This model was developed from 2007 through vigorous promotion by MOCA, the Central Organization Department of the Communist Party of China, and the Shenzhen Municipal Government. The model aimed to develop a social work development modality that could support development of a modern social work system with Chinese characteristics. The model was characterized by “government promotion and non-governmental organization operation", with “non-governmental organization operation" regarded as a key social work system. Government procurement of social work posts became the starting point for gradually exploring government procurement of social work service mechanisms. By 2010, government procurement of social work services in Shenzhen had developed into a combination of post-based and project-based purchasing. By 2012, this focus had advanced to the development of community social work services.[47] The Shenzhen model had weaknesses but its initial practices had a significant impact on the promotion of government procurement of social work services.

### 3. Developmental Stage

94. This stage was characterized by unprecedented government policy support for social work and elderly care services. This resulted in the project system becoming the mainstream mode for government procurement of social work services. Nongovernmental social work service organizations subsequently expanded and social work and elderly care services began to intersect within the community.

95. Following commencement of the national 12th Five-Year Plan (2011–2015), elderly social work practice entered a stage of rapid development and a breakthrough occurred in social work service policies:

(i) In 2012, MOCA and the Ministry of Finance jointly issued *Guidelines for Government Procurement of Social Work Services.* This was the first time that government had issued comprehensive, top-level design for the procurement of social work services. In the same year, the central government decided to build a public finance subsidy mechanism to support and nurture social service organizations. A series of national policies were promoted and government procurement of social work services became widely implemented nationwide. As a result, social work service organizations increased from 100- 200 at the end of the 11th Five-Year Plan (2010) to 4,686 at the end of the 12th Five-Year Plan period (2015).[48]

(ii) **Government procurement of social work services entered project operations.** The project system became the dominant mode for procurement of social work services, and the experience of Guangzhou Municipality was particularly remarkable. In 2010, Guangzhou followed the experience of Hong Kong, China and Singapore and began purchasing integrated family services

[46] Wang SB and Ruan YQ. The development of social work in China in the context of building a harmonious society. Social Sciences in China, 2011(9):128–140.
[47] Xu XH. The emergence and development of local supervision in Shenzhen mode. Social Work China: www.swchina.org, 2015/09/08
[48] *Report on Development of Social Work in China 2015* (excerpts). China Philanthropy Times website: http://www. gongyishibao.com /newdzb/html/2016-03/08/content_13619.htm?div=-1), 2016/03/08.

from social work service institutions in 20 pilot streets. Its procurement funds exceeded CNY50 million. By 2012, the integrated family service mode was in full operation, covering 138 streets, and with procurement funds of CNY300 million. Since 2013, procurement funds have exceeded CNY300 million annually.[49]

(iii) **New guidelines for social work services** for the elderly. In January 2016, MOCA released its Guidelines for Elderly Social Work Service.[50]

(iv) **Formation of a social work service model** based on "Joint development of the community, social organizations, and social workers" in which the community acted as a platform, the social organization as a vehicle, and social work professionals provided the support mechanism. In October 2015, MOCA held a meeting on community social work in Chongqing Municipality to promote the model. This resulted in the community becoming the main field for social work services.

96. **The elderly care service system** made great progress during the 12th Five-Year Plan:

(i) Basic elderly care services were referenced in the government agenda. The 2011 Social Elderly Care Service Construction Plan (2011–2015) prioritized ESD within the wider expectation that the needs of all elderly should be considered and met.[51] In 2013, the State Council promulgated the Opinions on Accelerating Elderly Care Services which emphasized a "focus on meeting the care service needs of ESD and ensuring access to basic elderly care service for all".[52]

(ii) A series of policies were released and a basic mixed economy framework of "government led, multi-party participation" in elderly care service provision took form. In 2013, the State Council Opinions on Accelerating Elderly Care Services and other policy documents clarified that social forces (i.e., nongovernmental entities such as private enterprise operations and not-for-profit social organizations, NGOs etc.) were to gradually but increasingly play an important role in elderly care services and government procurement of social services. As a result, nongovernmental and private care service institutions for the elderly developed rapidly.

97. **In summary,** strong government support encouraged the rapid development of two major carriers for elderly social work services: (i) social organizations engaged in social work and (ii) the field of elderly care. These resulted in the growth of social work organizations focused on services for the elderly. Elderly care service institutions also explored a variety of ways to recruit social workers. This led to the community becoming the main field for social work and elderly care services, and a growing intersection between single function and multi-function elderly social work delivery at the community level.

## D. Social Work Service Delivery Modes for the Elderly

98. PRC social work service delivery increasingly involves multiple parties. Firstly, there is the service provider. By its nature, this can be either a governmental or nongovernmental

[49] The *Blue Book of Social Work In China (2010-2012);* Ifeng Finance Website: http://finance. ifeng.com/a/20140723 /12776752_0.Shtml.

[50] Ministry of Civil Affairs. 2016. *Guidelines for Elderly Social Work Service* (MZ/T 064-2016). Ministry Of Civil Affairs Websit http://www.mca.gov.cn/article /zwgk/tzl/ 201602/20160200880380.shtml 2016/02/23.

[51] The State Council. 2011. *Social Elderly Care Service Construction Plan (2011-2015).* The State Council Website: http: //www .gov.cn/xxgk/pub/govpublic/mrlm/201112/t20111227_64699.html.

[52] The State Council. 2013. *Opinions on Accelerating Elderly Care Services*. Ministry Of Civil Affairs Website: http://jnjd. mca.gov.cn/article/zyjd/zcwj/201310/20131000534003.shtml.

organization. The international trend toward public service supply reform takes the separation of service purchasers and providers as an important strategy for improving service efficiency and effectiveness. The rapid development of nongovernmental social work institutions has created a necessary premise and possibility for such a separation of service purchasers and providers. Service delivery can therefore be divided into "endogenous" and "purchase" forms according to whether the service purchaser and provider are the same or a separate entity. Elderly social work service delivery can be classified into four basic models based on the "nature of service providers" and "whether the service purchaser and provider are separate or the same", (see Table 28). These models are (i) the government endogenous model (in which government provides services directly), (ii) the nongovernment endogenous model (nongovernment institutions provide services directly), (iii) the nongovernment procurement model, and (iv) the government procurement model.

**Table 28: Four Basic Models of Social Work Service Delivery for the Elderly**

| Relationship between the Service Purchaser and Provider | Governmental Organizations | Nongovernmental Organizations |
|---|---|---|
| Endogenous model | Government administrative social work posts<br>Public elderly care service institutions set up social work posts or social work departments | Nongovernmental elderly care service institutions set up social work posts or social work departments |
| Procurement model | Government purchases services from social work institutions and then delivers them to communities or elderly care service institutions | Nongovernmental elderly care service institutions procurement services from social work institutions |

### 1. The Government Endogenous Model

99. This model has two defining characteristics:

(i) **An initial phase of government operated social work services.** This is common in the early stage of development in which social work services are promoted, and led, by government. Public elderly care service institutions provide social work services directly through the establishment of social work posts or social work departments. Some public elderly care service institutions, such as Shanghai, Beijing, and Guangzhou (discussed above), also introduced professional social workers. However, this model of government operated social work services does not last long and is soon replaced by the model of government procurement of social work services.

(ii) **Transformation of government administrative social work into professional social work.** This occurred in the transition from a planned economy toward a transitional society. Government has recognized that it forms an important step in constructing a service oriented government. In 2008, the (then) Ministry of Human Resources, (then) Ministry of Social Security and MOCA jointly issued *Guidance on Management of Post Setting-up in Civil Affairs Departments*, which

stipulated that social work posts were the main professional and technical positions in departments of civil affairs.[53]

100. At present, there are two main channels for creating social workers in the field of civil affairs. The first is through professional social work training undertaken by departments of civil affairs. Since 2006, the civil affairs administration has provided many training courses in professional social work knowledge each year for staff of the social services system. The second channel is through examination and award of professional social work qualifications. The national social work professional qualification examination was first administered in 2008 and candidates have increased annually, with staff from the civil affairs administration comprising an important component of candidates (40% of national social work qualification examination candidates in 2010).[54]

### 2. Nongovernment Endogenous Model

101. Social workers usually form an indispensable and integral component of international elderly care service institutions. However, professional social work in the PRC remains far from being deeply embedded in the elderly care service system. As mentioned above, elderly care service institutions only began to involve social workers in 2000, and only then in public institutions. Moreover, the speed of social worker engagement in nongovernment elderly care service institutions has been very slow.

102. A survey conducted in C city during 2014 found that only four or five out of 401 elderly care service institutions had social work positions, and these were all public or publicly-funded, although nongovernmentally managed. Follow-up interviews with 48 nongovernmental elderly care service institutions revealed that most directors had not even heard about social workers, or misunderstood that social workers were volunteers, and believed that there was no need for social work services. Some responded: "What can a social worker do? Can social workers improve the occupancy rate? You know it's not profitable to run elderly service institutions. The labor costs are so high that we have to be very careful on spending…This doesn't mean that social workers are unimportant. The fact is that we haven't developed to that extent. It's just not the time". (Person A in charge of a nongovernmental elderly service institution).

103. The introduction of social work into home-based care service agencies has also proved difficult. Still taking C city as an example: By August 2015, there were 77 qualified day care centers for the elderly in formal operation, with 83% nongovernmental or publicly funded but nongovernmentally managed. During January 2016, 54 of these were interviewed by telephone for this report. The results showed that only 11 (about 20%) of the 54 provided social work services, and of those 11 day-care centers for the elderly, only four had created social work positions. Of the other seven, four had purchased these services from social work institutions, and three had established cooperation with universities and students majoring in social work to provide elderly social work services.

104. Different factors contributed to this problematic situation: (i) The overall operation of nongovernmental or private-for-profit elderly service institutions is not functioning well. Consequently, these entities take a cautious and conservative attitude toward social work

[53] Ministry of Human Resources and Social Security and Ministry of Civil Affairs. 2008. *Guidance on Management of Post Setting-up in Civil Affairs Departments.* Ministry of Human Resources and Social Security Website: http://www.mohrss.gov.cn/rydwrsgls/SYDWRSGLSzhengcewenjian/ 200810/t20081008_83805.htm. 2008/10/08.

[54] Social Work Research Center, Ministry of Civil Affairs. 2013. *Reports on Development of Social Work in China (2011–2012).* Social Science Academic Press (the PRC).

services, which are also still developing. Interviewed directors of elderly care service institutions often cited operating costs, occupancy rates, breakeven points, bed subsidies and so on. From their perspective, provision of social work services within the institution should be based on the balance of cost and benefit and only considered after “hard-core” services such as personal care, medical care, and rehabilitation. (ii) Many professional social workers lacked local experience and so many elderly care service institutions, especially nongovernmental or private ones, remained suspicious or deeply doubtful of their efficacy.

105. PRC nongovernmental and private elderly service institutions are thus not motivated toward ‘endogenous’ social work services and their own development drive comes from external rather than internal factors such as related policies and the promotion of social work professionals in colleges and universities.

### 3. Nongovernment Procurement Model

106. Elderly care service institutions have begun outsourcing their social work services to emerging professional social work institutions. This will become another option for specialization within elderly care service institutions. However, relevant practice is presently insufficient in the PRC and empirical materials are quite scarce. The case of a social work firm interviewed in May 2016 may be helpful in understanding this model. The company is referred to as MY Beijing in this report.

107. MY Social Work Co. was founded in 2009 to promote welfare services for the elderly. At present, the institution is delivering outsourced services through three nongovernmental elderly care service institutions (hereafter called YL, SJ, and ZJ). Two are publicly funded but nongovernmentally managed (YL and SJ), and ZJ is a nongovernmental elderly care center.

108. YL has cooperated in a business capacity with MY since 2009. This cooperation was originally promoted by a government department as a pilot of social work service provision for the elderly since wider awareness of the role of social workers was lacking. The activity initially involved MY accrediting full-time social workers to provide free social work services through YL with MY taking responsibility for their salaries. This required MY to first know the needs of the residents covered by the YL institution and then to establish a trust relationship with those elderly to provide some entertaining leisure services.

109. Since 2009, this trust has developed and so, from early 2011, YL offered to procure half of the social work posts from MY. This occurred through a sharing payment for accredited social workers under the condition that they should also undertake administrative work. Although this increased the workload of the social workers, it also gave them an opportunity to participate in management of the institution. Social workers began to attend institution meetings and the concept of social work gradually became integrated into all kinds of activities and to produce professional and timely feedback on the needs of the elderly. MY accumulated a lot of practical experience in carrying out services for government procured projects, such as Alzheimer's disease interventions, fall prevention, management of chronic diseases, and music therapy. Social work services in YL gradually became specialized through the incorporation of MY experience. A “linkage mechanism of social workers and volunteers” also gradually formed with help from MY, and external resources continued to be introduced to YL. This allowed YL’s abilities, resource linkages, and integration to improve accordingly.

110. After seven years of cooperation and accumulation of professional experience, YL is now fully aware of the importance of social work services. Since 2016, it has started to

undertake more flexible project procurement, replacing the purchasing of posts and instead developing projects which are tailored to the needs of the institution. The efforts of MY social workers have won YL's recognition and established an equal partnership with other professionals. MY subsequently won an award in the first national professional social work service competition and has gained a corresponding reputation within the social work field. YL has formed an interdisciplinary collaborative model for elderly care services and its level of professionalism has significantly improved.

111. MY cooperation with the SJ and ZJ elderly care service institutions began in 2014 and 2015 respectively. MY Social Work Co. was invited to share its experience in a government-hosted seminar on management training. Because of its successful social work experience, directors of the SJ and ZJ elderly care service institutions took the initiative and sought to establish cooperation with MY. At first, their cooperation was limited to providing individual counseling and group activities for the elderly but it later moved toward wider cooperation. For example, the ZJ care center for the elderly worked with MY to procure and deliver government outsourced community-based elderly care services. MY contributed professional social work elements to ZJ, and ZJ provided a community resources platform for MY.

112. The director of MY social work company observed that procuring social work services from nongovernmental elderly service institutions had the advantage that these institutions often had more requirements for individualized services than did governmental elderly service institutions. This helped to promote the professional development of social work practice for the elderly. More importantly, nongovernmental purchasing channels allowed social work service organizations to reduce their dependence on government funds for outsourcing, thereby enhancing organizational independence and professional autonomy. It also helped to promote professional social work within the elderly care services and professionalization of the elderly care service system.

### 4. The Government Procurement Model

113. The PRC government has begun to reform its supply mechanisms for public services in response to the need for innovation in social governance and increasing familiarity with international experience. A new model of government procurement of services has replaced the traditional mode of government direct service provision. The essential characteristics of this new government service procurement model is its introduction of a public service market mechanism to attract social (nongovernmental) capital and social (nongovernmental) forces to participate in, and compete for, its activities. The corresponding role of government is also changing from that of a direct supplier of public services to a purchaser, regulator, and coordinator.[55]

114. Government procurement of social work services is an important institutional arrangement by which government can use fiscal funds to procure social work services from social organizations that employ professional social work practice through the institutions of a market and contracts.[56] [57] Under this new national policy, government procurement has become means for providing elderly social work services in the PRC. It allows elderly social work service entities to accumulate practical experience and to gradually become more specialized.

[55] Yue JL and Wen ZY. 2012. The new public administration and social service: The case of Hong Kong. *Journal of Public Administration Review.* 5(3):144–166.

[56] Ministry of Finance and the Ministry of Civil Affairs. 2012. *Guidelines on Government Procurement of Social Work Services.* 2012/11/14.

[57] Shenzhen Finance Commission and Bureaus of Civil Affairs. Implementing Framework for Shenzhen Government Procurement Of Social Work Service (Draft), 2015/08/11.

Government welfare support for ESD is also moving from a financial aid policy toward a more diversified service welfare approach in which social work service agencies and professional social workers will become the main supply channel for basic elderly care services. Key questions have become: (i) whether elderly care social work can move smoothly towards specialization, (ii) whether it can shoulder the responsibility of promoting professionalization of the PRC elderly care service system, and (iii) whether current and future basic care services for the elderly can be delivered effectively.

115. In practice, different models have formed within the government procurement of social work services such as the post system, the project system, the voucher system, and a project system subdivided into “service outsourcing” and “authorized operation”. These features are outlined below.

### a. The Post System

116. Procurement of social work posts refers government providing funds to government agencies, public institutions, and grassroots communities to purchase social work posts, and then for social work agencies to dispatch social workers to work at these posts and provide social work services. In 2007, Shenzhen City took the lead in exploring the model of “government procurement of social work posts”. By 2010, government had purchased over 1,300 social work posts, covering 13 related areas, and including elderly care service.[58]

117. The post system is a relatively conservative form of procurement with the advantage that it is simple and easy to implement.[59] [60] However, its weaknesses include the creation of a social work bureaucracy. For example, a study of government procurement of social work services in the cities of Guangzhou and Shenzhen revealed that creation of social work posts was rather arbitrary and subjective with neither government or the general public having adequate understanding of social work and neither the purchaser nor the undertaking party cognizant of the needs which had originally justified creation of the posts.[61] Consequently, dispatched social workers often functioned just as administrative assistants. Moreover, these problems made it difficult to undertake performance evaluation and supervision of services to be provided.[62] Clearly, the responsibility of social workers and their service content needed clarification.

118. Many scholars have also pointed to shortcomings in the salary system for purchasing social work posts.[63] Whereas a “one size fits all” salary policy is easy to operate, it does not consider or recognize a social worker's age, educational attainment, or ability, and the nature, content, or intensity of service work. This resulted in a high turnover of social workers.

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[58] Wu GL. Government procurement services: from ‘the post’ to ‘the project’”, *Social Science Review*, 2013,28:147–149.

[59] Bin LP. Social work in China ‘embedded’ development model： based on a survey of Shenzhen City. *Journal of Social Work,*2011(4):35–37.

[60] Chen XH, Liu X, Wu QQ. New exploration of social work development in Jinan: The combination of posts and projects. *China Social Work*, 2012(33):42–43.

[61] Liu ZP and Han Y. 2013. Government procurement of social work services under the perspective of transaction costs theory: model comparison and strategy choice - The practice Of Shenzhen and Guangzhou as examples. *Journal of Guangdong University of Technology (Social Sciences Edition).* (6):70–75.

[62] Liu ZP and Han Y. 2013. Government procurement of social work services under the perspective of transaction costs theory: model comparison and strategy choice - The practice Of Shenzhen and Guangzhou as examples. *Journal of Guangdong University of Technology (Social Sciences Edition).* (6):70-75.

[63] Ma GX and Ye SH. 2014. The mechanism, predicament and prospect of government procurement of service from social work institutions. *Journal of Guangdong University of Technology (Social Sciences Edition)*. 14(1):49–55.

### b. The Project System

119. In 2010, government procurement of social work services entered the project system stage in which government outsourced a public service package to social service organizations through public bidding or directional delegation. The project system included both outsourcing of individual service projects and the outsourcing of public service institutions.[64] The latter was also called "authorized operation".

#### i. Service Outsourcing

120. Service outsourcing has become a mainstream method for PRC social work service delivery. In practice, it takes two basic forms: directional delegation and public bidding. This reflects both inertia in the traditional system and a lack of adequate social organizations, As a result, government procurement of social work services is mostly entrusted and non-competitive, with public bidding being relatively restricted and mainly occurring in municipalities and cities such as Guangzhou, Shenzhen, Beijing, and Shanghai.

121. The service outsourcing model reveals some striking advantages compared with the post system.[65] [66] Firstly, government procurement of social work services has become more targeted, with clearer content and responsibilities, and its use of funds is more efficient and productive. Secondly, its relatively clear separation between government and social work service organization functions has reduced administrative constraints to service operation, thereby enhancing social organization flexibility and better ensuring the professionalism and independence of social work services. Thirdly, the project system can be more easily supervised, evaluated and flexible than the post system.

122. However, various challenges exist in practice, and in the adaptation of international experience, in which outsourcing is already the main means of public service supply for many countries. Outsourcing in those countries is implemented on the basis of relatively mature social welfare organizations. However, in the PRC, public service outsourcing is being extended where there are insufficient acceptable social organizations and where one of the purposes of government procurement of services is actually to promote the development of such social organizations.[67]

#### ii. Authorized Operation

123. In the authorized operation model, government retains ownership of social service facilities but empowers social organizations to operate and provide corresponding public services through public bidding or directional delegation.

124. Authorized operation actively promotes the development of social work service organizations. For example, in Guangzhou and Shenzhen cities, the development of social work service organizations has been accompanied by the creation of an authorized and comprehensive community services arrangement. The Guangzhou "integrated family service

[64] Yan W. 2007. The conception of government procurement of social services. *Journal of Social Work.* (11):8–9.
[65] Yi SG. 2013. Ways to development for the non-governmental social work service agencies—Shenzhen as example. *Journal of Social Work.* (5):21–25.
[66] Wu GL. 2013. Government procurement services: from 'the post' to 'the project'". *Social Science Review*. 28:147–149.
[67] Yue JL and Guo YH. 2013. The research on the relation between government and NGO—from the welfare pluralism perspective. *Dong Yue Tribune.* (7):5-14.

center" project and the Shenzhen "community service center" project exemplify social work institutions undertaking authorized operation. The Guangzhou Integrated Family Service Project started as a pilot in 2010, then expanded its coverage to more than 130 streets by 2012, and over 170 integrated family service centers in 2014. These centers contract social work services through public bidding, then undertake operation and provide services.[68] The Guangzhou municipal government also studied the "lump sum grant subvention system" experience of Hongkong, China. Under this approach, the municipal government allocates CNY2 million annually to each integrated family service center and requires it to have 20 staff members, at least 14 of whom are professional social workers.

125. The Shenzhen Community Service Project in resembles the Guangzhou model in being outsourced to social service agencies, most of which are social work service organizations. The Shenzhen municipal government allots CNY500,000 annually to each community service center, and requires it to have more than six full-time staff, over 60% of whom are registered social workers, and with center administrators or directors selected from among professional social workers.[69] By the end of 2015, Shenzhen had built about 700 community service centers that provided comprehensive community services and met the goal of one center per community.[70]

126. Experience from Guangzhou and Shenzhen indicates that the authorized operation model empowers social work service agencies with greater autonomy than does the "outsourcing single service project". And it is conducive to building an interdisciplinary care service complex for the elderly that takes social workers as its core. However, performance evaluation of authorized operation is more complex than for single service outsourced projects.

127. The short duration of social organization participation in the operation and management of public elderly care service institutions means that the advantages and disadvantages of "the authorized operation" model still require further observation and exploration. However, the promotion of home and community-based elderly services is helping the government to enlarge the scale of home-based elderly service centers, day care centers, and other community service entities. There is reason to believe that increasing numbers of social organizations will emerge and mature to undertake operation and management of community elderly service facilities, and that this will further promote the development of social organizations engaged in elderly care.

### c. Voucher System

128. The voucher system is a form of government procurement of public services frequently used in western countries. It involves government issuing consumption coupons or vouchers to individuals who become entitled to certain goods or services. The coupons are then submitted to a specific service producer, and the government encashes those vouchers it receives from producers.[71] After trials of home-based elderly care services in Shanghai and other areas in 2000, the elderly service coupon voucher system was widely adopted in the PRC and has been used for over a decade.

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[68] Source: Guangzhou Community Service Website: http://www.96909.gd.cn/index.htm.

[69] The Operating Standards of Community Service Center In Shenzhen. Shenzhen Civil Affairs Website: http://www.szmz.sz.gov.cn/xxgk/ywxx/shxx/zcfg/201110/t20111018_1744115.htm.

[70] Happiness and sorrow: Shenzhen community service center will amount to 700 at the end of the Year. *China Social Work Times*: http://www.aiweibang.com/yuedu/44698449.html.

[71] Zhang RL, Kui MM and Xu LH. 2012. The problems and causes of voucher system in purchasing pension services—Taking the pension services policies in Beijing as an example. *Social Science of Beijing.* (3):59–62.

129. The voucher system is essentially a subsidizing demander system for government procurement of services. It gives clients more autonomy and has some other striking advantages. It provides ESD with a protective net and ensures that limited resources are used to meet the needs of those elderly in urgent need. It can also enhance the effectiveness and efficiency of public service expenditures and equalize basic care services for the elderly. The autonomy it gives to clients can also improve their position and make service delivery more flexible, both of which are conducive to promoting effective links between the demand and supply of basic elderly care services.

130. However, the voucher system also has some disadvantages in practice. A survey of voucher use by the Beijing elderly indicated that voucher user choices were limited through lack of sufficient, good quality social service institutions.[72] As a result, the elderly still had to consume these services even though they could not satisfy their needs. Research of a home-based elderly care service in Anhui also found that lack of supervision encouraged some designated service institutions to break the rules and purchase vouchers at a low price.[73]

131. The overall literature on voucher system use in PRC social work remains insufficient. The initial elderly service voucher system was basically limited to personal care and housekeeping services. More recently, voucher service items in the eastern coastal cities of Shenzhen, Guangzhou, and Shanghai have gradually expanded to cover psychological support, hospice care services, and other activities. However, exploration and use of the voucher system still requires further effort. Moreover, it seems that the elderly lack sufficient knowledge and acceptance of social work to buy such social work services.

### E. Barriers to Social Work Service Delivery Modes for the Elderly in Special Difficulties and Recommendations

132. MOCA has begun to explore elderly social work service modes and effectively meet the diverse needs of ESD through pilot projects on home-based and community-based social work service. In 2014 and 2015, MOCA used state lottery funds to procure social work services from social work service organizations. Pilot projects were undertaken in 15 villages and towns and at 35 street-level neighborhoods in the six provinces of Guangdong and Fujian in the eastern PRC, Heilongjiang in the northeast, Jiangxi in the central region, and Sichuan and Qinghai in the poorer west.

133. The implementation of these projects played a positive role in promoting elderly social work service in the PRC. However, further development has experienced many challenges and some restrictive factors have resulted in deviation from the expected goal of social work service for ESD. For instance, field surveys and interviews with directors of social work service agencies for this report indicated that the main constricting factors were: (i) lack of a clear definition of ESD, (ii) lack of effective methods and tools for identifying and targeting ESD, (iii) lack of stable sources of funding, and (iv) lack of adequate human resources. The literature review for this report also found more deep-seated constraints in government procurement of social work services. The following section analyses some of these factors that restrict social work service delivery for ESD and provides some recommendations.

[72] Zhang RL, Kui MM and Xu LH. 2012. The problems and causes of voucher system in purchasing pension services—Taking the pension services policies in Beijing as an example. *Social Science of Beijing*. (3):59–62.

[73] Ma GX and Ye SH. 2015. The local practice of government procurement home-based old-age services: achievements, challenge and prospect. *Shandong Social Science.* (7):125–130.

### 1. Lack of a Clear Definition of ESD

134. The definition of ESD used in this research is not limited to financial aspects but involves a multi-dimensional concept that includes health, social, psychological, and economic factors among others. ESD in the MOCA pilot projects included the oldest old, the elderly living in "empty-nest" households, those "left behind" alone in the countryside, having lost their only child, suffering from chronic diseases, unable to perform daily activities, and those living in poverty or on with low incomes etc.

**Table 29: Proportion of the PRC Elderly in the Six Categories of the Elderly, 2010**

| Categories of Elderly | Proportion of the Elderly Population (%) |
|---|---|
| Suffering from chronic diseases | 67.9 |
| Living in empty-nest households | 49.3 |
| With financial difficulty | 31.1 |
| Unable to perform daily activities (ADL disability) | 22.7 |
| Oldest old (80 years or older) | 11.8 |
| Without children | 1.9 |
| At least one of six categories | 89.6 |

135. However, this definition of ESD is too broad. On the one hand, it covers a high proportion of the elderly population. Table 29 presents a breakdown of the PRC elderly into six categories of elderly, in which at least one category covers almost 90% of all elderly. On the other hand, there is y insufficient evidence at present to indicate whether some elderly groups, such as empty nesters, should actually belong to the ESD group. In the past few decades, the proportion of elderly living in empty-nest households has risen considerably and several surveys show that it now approximates 50%.

136. Some scholars point out that "empty nesters" should not therefore be so labeled as they consider the increasing number of empty nesters represents a living style change rather than an emerging problem. Findings from Table 30 support this viewpoint. There is no obvious difference in the socioeconomic and health indicators of empty nesters and those with children, except that a slightly higher proportion experience social isolation. Both elderly empty nesters and those left behind alone in the countryside require governmental support. However, there needs to be more evidence that they actually belong to the category of ESD.

**Table 30: Socioeconomic and Health Indicators, by Living Arrangements, 2010**

| Indicators | Empty Nesters | Non-empty Nesters |
|---|---|---|
| Financial difficulty (%) | 30.9 | 31.2 |
| Perceived their health to be bad or very bad (%) | 23.8 | 24.9 |
| Chronic diseases (%) | 67.5 | 68.3 |
| ADL disability (%) | 21.1 | 24.2 |
| Depression (%) | 23.2 | 23.8 |
| Social isolation (%) | 39.7 | 36.3 |

137. On the basis of the above discussion, there should be a more robust definition of different kinds of ESD. **It is recommended that priority be given to the elderly with multiple**

**difficulties and complex needs, i.e., those who need care, and especially long-term care, but are in financial difficulties, and lack care resources and social support.** National elderly survey data was used to estimate the elderly unable to perform daily activities and one of the following features: (i) among the oldest old, (ii) living alone, (iii) with no living children, or (iv) facing financial difficulties. It was found that this group occupied 15% of the old population, or about 33 million people in 2010. The elderly who were completely unable to care for themselves and also had one of the four characteristics above accounted for 5% of the old population, or about 11million people in 2010.

### 2. Lack of Effective Methods for Identifying and Targeting ESD

138. Identification of ESD is currently undertaken through household visits and neighborhood or village committee lists of ESD. However, on-the-spot investigation indicated that some service recipients were not really ESD, but rather services free-riders. Thus the identification method and targeting mechanism require improvement.

139. It is advisable to identify ESD for inclusion in ESD targeted programs through high-risk screening criteria. Examples of such criteria would include, but not be limited to: the oldest old, those unable to perform daily activities (ADL disability) having a cognitive impairment, chronic, catastrophic, or terminal illness, those with a history of mental illness or suicide risk, with social issues such as a history of abuse and neglect, living alone or childless, and those living in poverty or with low incomes. In the process of identifying ESD, it is necessary to use obvious features such as being among the oldest old, living alone, without children, having a certificate of disability, or low income, and so on. If possible, a standardized assessment tool needs to be adopted to accurately identify ESD.

140. The PRC has been trying to develop such a comprehensive assessment tool for the elderly and has accumulated much valuable experience. Some research institutions are studying international geriatric assessment tools such as interRAI and hope to adopt these. InterRAI has already been used in 44 countries and regions worldwide. For example, Iceland has been successful in using InterRAI to better target ESD requiring nursing home support. InterRAI data analysis in Iceland revealed that many elderly people who should have been cared for in the community were actually being placed in nursing homes. This resulted in long admission waits for nursing home beds. Use of InterRAI allowed nursing homes to only accept those elderly in need of urgent care services. The average nursing home stay was thus reduced from four years to two and a half years. MDS-HC2.0 (the earliest version of interRAI) is also being used in Hong Kong, China to identify the need for admission to long-term care agencies. There, MDS-HC2.0 has been recognized by government, and is expected to be updated to interRAI-HC 9.1 in 2018. It is suggested that the PRC should make full use of international and regional experience to develop geriatric assessment tools, with particular attention to the reliability, validity, and feasibility of those tools.[74]

### 3. Lack of Stable Sources of Funding

141. Lack of funds is a significant obstacle for ESD social work services, especially in underdeveloped areas. For example, after the MOCA pilot ESD social work service project ended, some contracted agencies also terminated their social work services through lack of new funding sources. What caused this lack of funds? On the one hand, procurement of social work services by local government has not yet been included in the regular budgets of relevant

[74] InterRAI China: http://www.interraichina.org

agencies, and a stable scale and source(s) of funding has not been secured. Inadequate service procurement procedures have often meant that funds were not in place in time. On the other hand, social work service agencies lacked multi-financing channels and were highly dependent on government funding, lacked social donations, private or other investment channels, and their social fund raising capacity was weak.

142. **Special attention should be given to building regulatory systems for government procurement of social work services that enhance the stability and sustainability of government investment.** Procurement of social work services should be included in the regular government budget. It is necessary to establish a steady growth mechanism, create specially allocated channels to improve efficiency of government fund disbursement, and use the regular financial report and inspection system to ensure highly efficient use of the government funds for purchasing social work services. **It is also necessary to encourage and guide social (nongovernmental) capital into elderly social work services to build diversified funding mechanisms.**

### 4. Lack of Adequate Human Resources

143. The result of the ESD pilot social work service project run by MOCA indicates that service capabilities and service professionalism need to be improved. One important factor is personnel shortage, especially the lack of experienced social workers for the elderly, which is further exacerbated by low salaries and lack of professional career prospects.

144. It is recommended to expand elderly social work professional education. Special attention should be given to the practical abilities of social workers for the elderly. This involves expanding professional education for elderly care social work based on those universities and colleges which have existing social work programs. It also involves special continuing education for elderly social work to enhance the professional capacities of existing social work practitioners. Elderly care practitioners can also be trained as social work personnel through provision of basic training in social work and other disciplines, such as gerontology. In addition, it is important to strengthen career incentive mechanisms through a combination of material and spiritual incentives that address the needs of social workers for the elderly, and their material, emotional, and professional development needs. A sound incentive policy should be established to motivate social workers for the elderly to work sustainably at the grass-root level, to improve their social status and work enthusiasm, and to reduce staff turnover.

## F. Summary and Recommendations

145. This report reviews the development of elderly social work practice, analyzes advantages and disadvantages of various delivery modes for elderly social work, discusses the main factors that influence elderly social work service delivery for ESD, and proposes relevant countermeasures and suggestions. Its main conclusions are as follows:

▪ **Development of social work practice for the elderly in the PRC**
- The development of social work practice for the PRC elderly is a gradual process of increasing integration into the elderly care service system.

▪ **Delivery of social work services for the elderly**
- In practice, different types of models have formed for government procurement of social work services, including the post system, project system, and voucher system. Each model has its own advantages and disadvantages.
- Under the impetus of national policy, government procurement has become the main

method for delivering elderly social work services in the PRC. It helps services to accumulate practical experience and gradually become more specialized.

▪ **Barriers to social work service delivery for ESD**

- MOCA has implemented pilot projects on home-community based social work services for ESD in order to explore elderly social work service methods and effectively meet the diverse needs of ESD through government purchases of services. These pilot projects have played a positive role in promoting social work services but have also experienced many challenges.

▪ **Policy recommendations for ESD social work service delivery**

- **Use high-risk screening criteria to target for inclusion in ESD programs.** Examples of high-risk screening criteria include, but are not limited to, the oldest old, those unable to perform daily activities (ADL disability) or having cognitive impairment; chronic, catastrophic, or terminal illness, a history of mental illness or suicide risk, social issues such as a history of abuse and neglect, who are living alone or childless or living in poverty or with a low income. Make a clear definition of different kinds of ESD. **Focus on identifying older persons who are in most need and can most benefit from these programs. The elderly with highest priority are those with multiple difficulties but without supportive resources**, e.g., the disabled elderly who are poor, live alone, or lack social support and care resources.
- **Improve the ESD identification method and targeting mechanism.** Identify ESD through high-risk screening and develop standardized geriatric assessment tools to accurately identify ESD. Draw on domestic and international experience with geriatric assessment tool development and application, giving particular attention to reliability, validity, and feasibility of the assessment tools.
- **Build regulatory systems for government procurement of social work services in order to enhance the stability and sustainability of government investment.** Procurement of social work services should be included in the regular government budget. It is necessary to establish a steady growth mechanism, set up specially allocated channels to improve efficiency of government fund disbursement, ensure high efficiency of government funding for purchase of social work services by preparing regular financial reports and developing an inspection system. It is also necessary to build diversified funding mechanisms and encourage social capital into elderly social work services.
- **Expand professional education and training for elderly social work** with special attention to the practical abilities of social workers for the elderly.
- **Build career incentive mechanisms.** Provide a combination of material and spiritual incentives that meet the needs of social workers for the elderly, including a sound incentive guarantee policy that can motivate elderly social workers to work sustainably at the grass-roots level, to improve their social status, work enthusiasm, and reduce staff turnover.

## III. GUIDELINES FOR SOCIAL WORK SERVICES FOR THE ELDERLY IN SPECIAL DIFFICULTIES

146. The PRC has a significant number of ESD and they are the heaviest users of social and medical services. Causes of ESD are multifaceted and so ESD service provision should be comprehensive in nature. **The ESD require a combination of targeted poverty-reduction measures and affordable and comprehensive medical and social services.** The goal of these measures and services is to promote the psychological, physical, and social functioning of ESD at the optimal level possible. Social workers can play leading roles in meeting these needs of older people and their families. They will become even more essential as ESD, and their complex needs, become an increasing percentage of all clients served by social workers.

147. MOCA formulated a Guideline for Elderly Social Work Service that was released in January 2016. It aims to energize the professional role of social work in elderly care services, to synthesize and promote elderly social work practice and experience for different localities, to scientifically standardize and correctly guide elderly social work service behavior, and to guarantee the quality of social work services for the elderly, This following draft guideline for ESD is based on the MOCA Guideline for Elderly Social Work Service and proposes further enhancements to develop practice in this area.

## A. Scope

148. This draft guideline provides terms and definitions for ESD social work services, service principles, content, methods, procedures, management, personnel requirements and service guarantees.

149. The guideline is suited to social work services for ESD and their families.

## B. Terminology and Definitions

150. The following terms and definitions are applicable to this guideline.

### 1. Elderly Care Social Work Services

151. Elderly care social work services are professional activities directed toward the elderly and their families. Service provision is guided by professional values and ethics, and requires a unique combination of physical, psychological, social interventions, and family support, the goal of which is to maintain and improve the psychological, physical, and social functioning of the elderly and their families.

### 2. Elderly Care Social Workers

152. Defined as those engaged in elderly social work services and holding social worker qualifications, as distinct from volunteers and related workers who should operate under the guidance of a social worker.

### 3. Elderly with Special Difficulties

153. ESD are those with special physical, psychological, and/or financial difficulties, such as those over 80 years of age, who are poor, live alone, are childless, and unable to perform daily activities. They usually have multiple and complicated needs and need long term care and various resources.

### 4. Case Management

154. Case management is a method for providing services. It is a collaborative process in which a professional assesses the needs of the client and, when appropriate, the client's family, and arranges, coordinates, monitors, evaluates, and advocates for the multiple services needed from a variety of social service and health care agencies to meet the client's complex needs. In this process, professionals and workers from different service organizations communicate with each other, coordinate and provide services for the client through team cooperation. The aim is to improve service efficiency and, help the client out of difficulties. Case management

addresses both the individual client's bio-psychosocial-spiritual status at the micro level and the state of the social systems in which the services operate at the macro level.

## C. Service Guiding Principles

155. The MOCA Guideline for Elderly Social Work Service (MZ/T 064-2016) indicates that social work services for the aged should follow the principles for the elderly issued by the United Nations i.e., those of independence, participation, care, self-realization, and dignity. Social work services for ESD should particularly accord with the following principles:

### 1. Person-centered

156. Using person-centered and professional approaches that respect the ESD's sense of value and dignity, and provide services through attitudes of equality and a strong sense of work responsibility. Elderly people, regardless of their age, gender, ethnicity, disability or other conditions, are to be treated fairly. ESD are to be respected and protected in decisions related to their own interests and rights, especially concerning their living arrangements and care.

### 2. Needs-Oriented

157. Adopt a needs orientation and earnestly solve difficulties that ESD encounter. ESD should enjoy health care and a variety of social and legal services and maintain the highest degree of independent living and social adaptability. The elderly should be helped to improve their independence and enable them to be better protected and cared for.

### 3. Strengths Perspective

158. The strengths perspective recognizes strengths and abilities of the individual to cope with problems. In the process of providing services, it is important to believe that ESD have their respective advantages and potential, and to encourage them to give full play to their abilities, help them solve their own problems, and to mobilize for change.

### 4. Resources Integration

159. Social workers take a person-in-environment perspective and analyze ESD difficulties by looking at reciprocal relationships between ESD, their family members, friends, neighbors, communities and service organizations in order to identify, link, and integrate the resources required, and help ESD enhance their resources and ability to make use of the resources.

### 5. Equal Participation

160. In the service process, social workers should strive to create a friendly environment for the elderly, remove age and gender discrimination and restraints to older people participating in activities of social life, and to encourage and support the elderly to participate in the formulation and implementation of welfare policies which have a direct impact on their wellbeing, as well as promoting the social participation of the elderly.

## D. Service Content

### 1. Needs Assessment and Resources Linkage

(i) Carry out a needs assessment for ESD and identify their needs in all aspects, such as medical, social, psychological, financial, and housing.
(ii) Organize or participate in drafting care plans for ESD.
(iii) Coordinate care and long term care arrangements, including home-based care, community day care and institution-based care, in order to make the service delivery system more efficient and user-friendly.
(iv) Assist in forming links to government and all kinds of social resources, and organize or coordinate other professional organizations and volunteers to provide needy ESD with home health care, personal care, spiritual care, hospice care, health promotion, respite care and home modification.
(v) Assist eligible ESD to apply for government living assistance, medical assistance, housing assistance, temporary assistance and other social assistance.

### 2. Psychological Support and Crisis Intervention

(i) Supply the needy elderly with psychological counseling, mood management, and cognitive regulation to avoid or overcome depression, anxiety, loneliness and other psychological distresses.
(ii) Identify and evaluate crises faced by the elderly, co-ordinate the development of a crisis intervention plan, including timely treatment of suicidal intentions, injury, and other behavioral problems that may endanger life.

161. Help the elderly to adapt to changed life-roles, to redefine the value of life in old age, to understand the meaning of life, and to inspire confidence and hope in life.

### 3. Services for Upgrading Ability and Social Integration

(i) Provide family counseling to enhance the ability of ESD families to cope with problems and difficulties.
(ii) Integrate the use of various strategies, including personal empowerment and self-help, mutual help among neighbors, linkages with volunteers and family caregiver support, to reconstruct ESD social support networks and to enhance the ability of the elderly for social adaptation and to acquire support resources.
(iii) Develop culture, sports, entertainment and other activities suitable for the elderly, establish elderly interest groups, enhance their participation in social activities, and enrich their social lives.
(iv) Enable the elderly to actively participate in various kinds of voluntary services, nurture elderly volunteer groups and develop elderly volunteer service groups.
(v) Expand channels for elderly community participation and promote social integration of the elderly.

### 4. Advocacy and Protection of Rights and Interests

(i) Provide information and consulting services for the elderly, including on a variety of services and resources, and help ESD understand laws, regulations, and social policies related to the elderly.

(ii) Carry out social publicity and public education to protect the elderly from discrimination, insult, and other unfair or unreasonable treatments and to maintain and protect the rights and interests of the elderly.

(iii) Collect and analyze data on the implementation of elderly related laws, regulations, and social policies, and give timely feedback to the government, reflect the demands of ESD, and promote the improvement of ESD related social policies.

## E. Methods for Providing Services

### 1. Casework and Group Work

162. Social workers shall provide a variety of services for ESD and their families on the basis of one to one or group work, such as family counseling, psychological support, and crisis Intervention.

### 2. Case Management

163. Case management aims to facilitate collaboration among various services and resources to address the biomedical and psychosocial needs of clients and to better provide effective and appropriate social and health services for ESD with multiple needs.

### 3. Community Work and Social Development

164. Social workers work with and rely on the community, through social mobilization, community education and advocacy, to make full use of and integrate community resources, and to identify, cultivate, and develop new community resources to provide a range of services for ESD and their families.

### 4. Teamwork and Interdisciplinary Collaboration

165. Social workers should not only be responsible for, but also work as, gate keepers to link ESD care and the service team and to enhance multidisciplinary cooperation. Services and care will be improved for ESD and their families through effective communication, collaboration and information sharing between different disciplines of professionals.

## F. Procedures for Providing Services

### 1. Identification of ESD and Their Access to Programs for ESD

(i) Announce and publicize information about social work service programs for ESD.

(ii) Use high-risk screening criteria to assess for inclusion in ESD programs. Examples of high-risk screening criteria include, but are not limited to: the oldest old, those unable to perform daily activities (ADL disability) or having cognitive impairment, those with chronic, catastrophic, or terminal illness, a history of mental illness or suicide risk, or with social issues such as a history of abuse and neglect, or living alone or childless, or living in poverty or on low income.

(iii) Focus on identifying elderly who are in most need and can most benefit from the programs. The elderly with highest priority are those who have multiple difficulties without supportive resources, such as the elderly with disability who are poor, who live alone, or lack social support and care resources.

(iv) Identify ESD who are willing to receive the services, introduce them to the social work service programs, and then sign informed consent forms, if appropriate.
(v) Build relationships of trust with older people who are included in the programs.

### 2. Assessment of Needs and Resources

166. The following tasks should be completed, including but not limited to:
(i) Completing bio-psychosocial assessment and identifying client needs using standardized tools, where appropriate. The components of the assessment may include medical, functional, social, psychological, financial, housing conditions, strengths and resources, and obstacles to accessing resources. Data required for the assessment can be from many sources, such as client interviews, family members or caregivers, and medical records. If necessary and appropriate, conduct an interdisciplinary and comprehensive evaluation.
(ii) Identify the major problems that the client needs to address, and work with the client and the client's family members to determine the priorities for a solution.
(iii) Give priority to identifying and evaluating the crises or potential crises faced by the client, such as abuse, suicide risk, harm to others, and other behavior problems which may endanger life safety.

### 3. Development and Coordination of a Care Plan

167. The following tasks should be completed, including, but not limited to:
(i) Inviting the client and the client's family members to participate in making a care plan.
(ii) Establishing service goals and making indicators to assess these services.
(iii) Determining the care plan to achieve the established goals, including service type, service provider, resources needed by the client, tasks and responsibilities of the related parties, potential challenges and coping strategies, and a plan implementation schedule.

### 4. Service Implementation and Coordination

168. The following tasks should be completed, including, but not limited to:
(i) Ensuring a person-centered approach to service implementation.
(ii) Providing individual, family and group services focused on the maintenance and enhancement of the client's physiological, psychological, and social functioning, developing the client's self-management skills, and promoting the aged, families, and related personnel to make full use of existing resources.
(iii) Fully exploring and accumulating community resources, and coordinating and linking the formal and informal service resources needed by the client.
(iv) Maintaining regular communication with both the client and formal and informal providers, addressing and facilitating the resolution of discordant issues, identifying and facilitating the management of conflicts, and eliminating obstacles to accessing resources.

### 5. Service Monitoring and Evaluation

169. The following tasks should be completed, including, but not limited to:
(i) Determining the frequency of assessment according to specific conditions of the client.

(ii) Making ongoing assessments and documentation of effectiveness, efficiency, and quality of service based on planned assessment indicators, and regularly evaluating the extent to which the goals documented in the care plan have been achieved.
(iii) Defining problems existing in service implementation, and finding solutions, constantly revising and improving the care plan.

### 6. Termination of Services

170. The following tasks should be completed, including, but not limited to:
(i) Decide whether to terminate services based on the completion of goals.
(ii) Consolidate positive changes and service effects achieved.
(iii) Avoid or deal with negative emotions that result from service termination.
(iv) Providing follow-up service after service termination.

## G. Qualifications and Professional Development

### 1. Qualifications

171. According to the MOCA Guideline for Elderly Social Work Service (MZ/T 064-2016), social workers for the elderly should be equipped with at least one of the following qualifications:
(i) Certificate of professional social worker level awarded by the state.
(ii) Degree or higher qualification from a recognized national social work professional college.

### 2. Skills and Knowledge Requirements

172. Social workers engaged in ESD service delivery should acquire theoretical and practical knowledge of social work for the elderly and the skills to apply it in practice. This knowledge includes, but is not limited to:
(i) Laws, regulations, and policies relating to the elderly and elderly care services.
(ii) Roles and functions of social work in elderly care services.
(iii) Ethics, values, theories, and practical skills of social work.
(iv) Basic knowledge of gerontology to conduct elderly social work services.
(v) Methods and tools for elderly assessment.
(vi) Knowledge of case management.
(vii) Needs and common difficulties of ESD and their families and skills on how to meet these needs or solve these difficulties.
(viii) Local elderly care institutions and community resources related to elderly care services.

### 3. Ethics and Values

173. Social workers in elderly care services should demonstrate a commitment to the values and ethics of the social work profession, and abide by the 2012 MOCA Guidelines for Social Work Professional Ethics. They should pay special attention to the following points when providing professional services for ESD:
(i) The primary mission of the social work profession is to enhance human well-being and help everyone to meet their basic needs, with particular attention to the needs of ESD. Understanding this mission is rooted in a set of core values

and ethics, including respect for clients, equal treatment and acceptance of clients, respect for the rights of knowing, privacy and self-determination.

(ii) Be honest, trustworthy, and responsible.

(iii) Establish an equal and mutual trust relationship with colleagues, other professionals, and volunteers, and respect their different opinions and work methods.

#### 4. Continuing Education Requirements

174. Social workers for the elderly should acquire continuing education in accordance with the MOCA 2009 Rules of Continuing Education for Social Workers so as to continuously improve the professional level of service and practical working capacity. The objective of continuing education is primarily to adapt learning to the needs of work and to improve social work service abilities for working with ESD.

#### 5. Supervision

175. Establish a supervisory system to enhance the professional skills, knowledge, and service capabilities of those social workers for the elderly who lack experience and have only been employed in this capacity for a short time.

(i) Social workers who act as supervisors should have supervision qualifications, share social work values and ethics, have acquired specialized social work knowledge and be equipped with solid practical experience and supervisory skills for social work for the elderly.

(ii) Supervisors should make supervision needs assessments, formulate supervision plans, and be committed to the development and promotion of social worker skills for supporting the elderly to provide quality service for ESD.

(iii) Social workers who act as supervisors should receive training specific to the supervision of social workers undertaking direct practice.

### H. Service Management

#### 1. Service Plan

176. Social work administrators in elderly care services should develop a social work service plan to define social work services and ensure their availability to ESD and their families. The service plan should include objectives, a scope of services, and implementation plans.

#### 2. Quality Assurance and Performance Evaluation

(i) Social work service quality control should be carried out in accordance with the MOCA *Guideline for Elderly Social Work Service* (MZ/T 064-2016).

(ii) Evaluation of ESD social work service performance should be conducted according to the MOCA *Guideline for Performance Evaluation of Social Work Service Programs* (MZ/T 059-2014) to evaluate quality and suitability of services, improve practice, and ensure competence.

### 3. Documentation and Informatization

(i) Social workers for the elderly should maintain records or documentation of social work services for ESD and their families, including basic information on the elderly, assessments, social work plans, services provided, and outcomes.
(ii) Establish an information system and database for ESD social work services, and conduct regular analysis of social work service information to be used in service performance evaluation, including related research and decision-making.
(iii) Documentation management should be conducted in accordance with the MOCA Guideline for Elderly Social Work Service (MZ/T 064-2016).

### 4. Risk Management

(i) Establish a sound system of risk management for social work services for the elderly, and develop practical and feasible risk plans and emergency plans.
(ii) Risk management should accord with the *Guideline for Elderly Social Work Service* (MZ/T 064-2016) issued by the Ministry of Civil Affairs.

### 5. Complaints and Dispute Resolution

(i) Establish a complaint mechanism to ensure that the elderly and their families are able to register complaints. Take effective measures to improve practices and service quality on the basis of complaints and suggestions received.
(ii) The management of complaints and disputes should accord with the MOCA Guideline for Elderly Social Work Service (MZ/T 064-2016).

## I. Service Guarantees

### 1. Staffing

(i) A sufficient number of appropriately trained, credentialed and experienced social work personnel should be on staff to plan, provide, and evaluate social work services for the elderly with special difficulties.
(ii) Elderly care institutions and urban and rural communities should be allocated social workers based on the number, and self-care ability, of clients, the types and complexity of services and other factors.

### 2. Work Environment

(i) Sufficient budget, space, facilities, and equipment should be available to meet the needs of professional social work service implementation for ESD.
(ii) Office space should be in line with requirements for a barrier free environment but also ensure privacy and confidentiality for case work, group work, working meetings, telephone calls and documentation.
(iii) Offices should be equipped with computers and network equipment in order to seek information on education and resources on the web, and to provide and manage social work services efficiently and productively.

# IV. A BROAD IMPLEMENTATION FRAMEWORK FOR ELDERLY IN SPECIAL DIFFICULTIES SOCIAL WORK SERVICE GUIDELINES

177. Social work is a value concept that cherishes ways of helping those who help themselves. It is also engaged in professional social service activities that use social work theories and practical skills to help clients relieve psychological pressure, promote their development capabilities, strengthen their social functioning, set up support networks, and improve their quality of life. Social workers are increasingly essential for addressing the complex needs of the elderly and their families. Strengthening social work services for the elderly, particularly ESD, is an essential element of building a modern elderly care service system.

178. Developing guidelines for ESD care is one of the key issues for promoting professional and community based social work and social services outsourcing, focused on ESD. This report has undertaken a literature review, field investigation, and analysis of ESD needs to outline a social work service guideline for ESD. The following section presents a broad implementation framework for these guidelines, including primary goals and objectives, guiding principles, main tasks and policy measures.

## A. Primary Goals and Objectives

179. The primary goals are to create a good policy environment and eliminate barriers such as shortages of human resources, material resources, and financial resources for carrying out ESD social work service guidelines and professionalizing social work for the elderly. The specific objectives are:

- (i) To establish and improve organizational and regulatory systems.
- (ii) To promote the development of social work service organizations for the elderly (SWOEs) and the construction of a service platform.
- (iii) To build a team of elderly social work personnel with a reasonable structure and high quality.
- (iv) To establish and refine tools for social work service planning, implementation, monitoring, and evaluation.
- (v) To set up and advance a sound policy and support system to promote community-based elderly social work services and to ensure its sustainable development.

## B. Guiding Principles

### 1. Upholding Needs-based and Integrated Development

180. The implementation of social work service guidelines for ESD should be based on the service needs of local ESD and a needs-oriented implementation plan. At the same time, elderly social work services ought to be regarded as an important part of the development of elderly care services. Whether the resources for elderly care are fully utilized and integrated and whether ESD problems are solved and their needs met will determine how well the service guidelines for ESD are implemented.

### 2. Adhering to the Principle of Being Government-led and Independence of Social Organizations

181. It is the responsibility of government to guarantee basic care services for ESD and it is necessary to give full play to the leading role of government in promoting services for ESD, and

carrying out organizational leadership duties, policy support, financial investment, and supervision and management. It is also necessary to transform government functions, build healthy relationships between government and social organizations and to give full play to the autonomous function of social work organizations in improving service relevance, quality and efficiency.

### 3. Adhering to Professional Guidance, Innovative Development

182. Further promoting the popularization and application of professional social work values, knowledge, and methods is a basic requirement for the implementing guidelines. It is necessary to promote and professionalize elderly care services with social work theories, methods, and skills.

### 4. Sticking to Classified Implementation and Steady Progressing

183. Implementation of the guidelines should be coordinated with the level of local economic and social development and the capability to deliver social work services. The pace and means for implementing the guidelines should accord with respective characteristics for PRC urban and rural, eastern, central and western regions, and ethnic autonomous and minority areas. At the same time, each locality must constantly improve its policy environment, broaden service resources, and improve service capabilities to carry out the guidelines and ensure the sustainable development of social work service for ESD.

## C. Main Implementation Tasks

### 1. Increasing Awareness of Service Standardization

184. The ESD social work service guidelines provide important technical support for delivering services and upgrading service levels and quality. It is crucial to raise awareness of service standardization, especially among relevant staff such as government administrative social work personnel, administrators in social work service organizations, and community-based elderly care service organizations and elderly social workers to ensure success in implementing the guidelines.

### 2. Strengthening the Training Work

185. Establish a training system for social work service standardization and compile training materials on social work service guidelines for ESD. Provide training to government social work administrative personnel, administrators in social work service organizations and community-based elderly care service organizations and to social workers for the elderly. The training should help these groups to understand roles and functions in social work for the elderly, the principles, content, procedures, and basic methods of social work services for ESD, and to improve their abilities for ESD screening and identification, needs assessment, planning, service evaluation and contract management.

### 3. Undertaking Pilot Work

186. The aim of pilot work is to establish social work service mechanisms for ESD. It attempts to create a group of standardized service pilot areas and institutions within two to three years, and to create and test models which can be followed and expanded. In this way, the pilot areas and institutions can create good examples and provide constructive experiences for fully

implementing social work service guidelines for ESD. During this process, related research should be undertaken so that problems in the pilot work are detected, related measures taken, and then improved, and good or typical experiences summarized and extended.

#### 4. Strengthening Supervision

187. A supervision system for implementing the standard guidelines needs to be devised and strengthened by linking guideline implementation with relevant incentive policies. Regular performance evaluation of the ESD service guidelines will be undertaken and service satisfaction of ESD and their family members included in the evaluation indicator system to achieve synchronous improvement in guideline implementation and service quality.

### D. Measures to Promote Implementation

#### 1. Establishing Sound Organizational and Regulatory Systems

188. The organization and guiding of social work services for ESD should be strengthened in accordance with the principles of “government leading, the civil affairs administration being responsible and social forces participating”. Departments of civil affairs at all levels should include social work services for ESD in their overall planning for both social work and elderly care services and be responsible for the organization, coordination, and regulation of social work services for ESD. In addition, the local departments of civil affairs at all levels should build the work mechanisms for “close cooperation, co-promotion, steady and high efficiency”, conduct situation analyses, and develop work plans, in accordance with the situation analysis, to implement the guidelines and develop elderly social work services for ESD.

#### 2. Promoting the Construction of Elderly SWOs and Service Platforms

##### a. Strengthening Development and Capacity Building of Nongovernmental SWOEs

189. The cultivation and development of SWOEs should be included in the programs for incubating nongovernmental SWOEs and given priority in accordance with the 2014 MOCA Opinions on Further Accelerating the Development of Non-governmental Social Work Service Organizations. Regions or places with the required conditions are encouraged to set up special funds to help new and startup SWOEs to develop through venture philanthropy, subventions and incentives, provision of office space, and fee reduction. SWOEs are also encouraged to broaden their funds base, obtain financial support from enterprises, foundations and all sectors of society, and to strengthen their abilities for self-development.

190. Further development of SWOE capacity is essential to provide quality services for ESD, including leadership, innovation and development, resource integration, and project management.

##### b. Broadening Service Platforms for Community-based Social Work for the Elderly

191. Promote construction of service platforms for delivering social work services to ESD based on available community resources. In streets or townships with community-based elderly care organizations, such as street (township) elderly care centers, day care centers, and community comprehensive family service centers, encourage these organizations to employ

elderly social work professionals. For streets or townships where there are no relevant service organizations, mobilize these streets or townships to set up community-based elderly care organizations and equip them with social work for the elderly personnel, or encourage qualified social organizations engaged in social work for the elderly to set up service stations in communities. Encourage SWOE that are implementing government outsourced community-based elderly care services to apply for government-funded ESD social work services to promote the coordinated development of elderly social work services and elderly care services.

### 3. Increasing Human Resources for Elderly Social Work Services

#### a. Expanding Professional Education on Social Work for the Elderly

192. Expand professional education on social work for the elderly based on those universities and colleges with social work programs. Review PRC and international experience to inform the establishment of suitable curricula and teaching standards. Implement further reforms to improve social work education modes, increase the proportion of practicum teaching, and establish a mechanism for the combination of classroom teaching and practical (site-based) education. Build a system for teacher participation in social work practice for the elderly, and encourage outstanding professionals in social work for the elderly to engage with frontline work and to teach in colleges and universities and also to attract high-level international professionals to work in professional social work education for the elderly.

#### b. Training Existing Elderly Social Workers and Related Personnel

193. Enhance the professional level of existing social work practitioners in elderly care work through special continuing education for social work with the elderly. Elderly care practitioners can also be trained as social work personnel through basic training in social work and other disciplines such as gerontology. Relevant workers engaged in community and home based elderly care, community development, or poverty reduction can also benefit from broad elderly social work training. In the absence of elderly social work professionals, community-based workers with appropriate training can help to provide basic social work for the elderly with special difficulties.

### 4. Establishing and Perfecting Tools for ESD Identification, Needs Assessments and Service Monitoring and Evaluation

194. Screening and identification of ESD, needs assessment, and service monitoring and evaluation are three key aspects that require higher technical skills in social work services for ESD. Learning and synthesizing PRC and international experience are necessary to strengthen the development of tools for screening and identification, needs assessment, social work service assessment for ESD, and to provide technical support for the implementation of social work service guidelines for ESD.

### 5. Perfecting and Pushing forward Incentive and Guarantee Systems of Social Work Service for ESD

#### a. Establishing Diversified Funding Mechanisms

195. Governments at all levels need to implement the 2013 General Office of the State Council Guidelines on Government Procurement of Services from Social Organizations and the Guidelines on Government Procurement of Social Work Services issued jointly by the Ministry

of Civil Affairs and the Ministry of Finance in 2014, and to include the expenses for government procurement of social work services for ESD in the public financial budget. The MOCA Guidance on Using State Welfare Lottery Funds for Procuring Services from Social Organizations allocates some welfare lottery funds each year to pay for ESD social work services. It is also important to encourage and guide social (nongovernmental) capital into elderly social work services in order to build diversified funding mechanisms.

196. Special attention should be given to building regulatory systems for government procurement of social work services in order to enhance the stability and sustainability of government investment. Procurement of social work services should be included in the regular budget of government. It is necessary to establish a steady growth mechanism, set up specially allocated channels to improve the efficiency of government fund disbursement, and to implement a regular financial reporting and inspection system to ensure government funds for purchasing social work services are highly efficient.

### b. Building Career Incentive Mechanisms

197. Create a combination of material and spiritual incentives to address the needs of social workers for the elderly, and establish a sound policy of incentive guarantees that addresses material, emotional, and professional development to motivate social workers for the elderly to work sustainably at the grassroots level, to improve their social status, work enthusiasm and to reduce staff turnover.

198. Relevant strategies include establishing a salary guarantee mechanism for social workers, and exploring the establishment of a salary guiding standard to ensure that the average salary of social workers at the grassroots level is not lower than the local average wage. Create an occupational safety protection and stress relief mechanism to effectively reduce job burnout and improve social worker job promotion mechanism and unblock channels for their career advancement. A system of reward and recognition for social work professionals should also be constructed in accordance with the national policy on commending and rewarding social workers for their excellent performance, outstanding ability, or exemplary performance as frontline social workers recognized by the general public.

### c. Establishing and Strengthening the System of Social Work Service Agencies to Contact Volunteers

199. Take nongovernmental social work service agencies as the platform. Manage volunteer recruitment, registration, organization, management, training guidance, and service records, and encourage volunteers to participate in social work service agency activities. Use the interaction between social work professionals and volunteers to lead and upgrade the level of specialized volunteering and associated organization to strengthen resources and social work personnel, broaden the scope of service and boost service efficiency.